INSTITUTE OF PUBLIC HEALTH
UNIVERSITY OF GONDAR

STATUS OF MEN INVOLVEMENT IN FAMILY PLANNING AND ASSOCIATED FACTORS: AN APPLICATION OF TRANS- THEORETICAL MODEL STAGES OF BEHAVIOUR CHANGE, DANGILA TOWN ADMINISTRATION, ETHIOPIA.

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EXAMINER

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Acronyms

ANRS :	Amhara National Regional State
AOR	Adjusted Odds Ratio
CI	Confidence Interval
COR	Crude Odds Ratio
CPR :	Contraceptive Prevalence Rate
CSA :	Central Statistical Agency
EDHS:	Ethiopian Demographic and Health Survey
FDRE:	Federal Democratic Republic of Ethiopia
FP:	Family Planning
HEWs	Health extension workers
HIV:	Human Immunodeficiency Virus
IUD:	Intrauterine Device
MDGs:	Millennium Development Goals
RH:	Reproductive Health
STI:	Sexually Transmitted Infection
TTM:	Trans-Theoretical Model
TVETI :	Technical and Vocational Educational Training institute
TV	Television

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Abstract

Introduction: Reproductive health matters, such as family planning, in its broader sense should be a concern for all not for just that of women; and it needs the attention of men, entire family and the society at large.

Objective: The objective of this study is to assess status of men involvement in family planning & associated factors using Trans-Theoretical Model stages of behavior change.

Methods: The study used a community-based cross-sectional survey conducted from March 26 to April 15, 2012 in Dangila town administration, Ethiopia. A total of 406 currently married men in the age group of 15-59 years were included in the study. All *Kebeles of the* town were considered for sampling. Study households were selected from each *Kebele* through systematic random sampling after stratification. Pre-tested, structured questionnaires were used for data collection. Both bivariate and multivariate logistic regression techniques were used to analyze the data using 95% CI.

Results: Overall 78.3% of married men were involved in family planning. The study participants were asked to respond the behavioral stages of their own and their wives separately. 288 (70.9%), 22(5.4%), 25(6.2%), 53(13.1%) and 18(4.4%) of the respondents were in pre-contemplation, contemplation, preparation, action and maintenance stages respectively. 73(14.8%), 29(17.1%), 23(5.7%), 53(13.1%) and 223(54.9%) of their wives were in pre-contemplation, contemplation, preparation, action and maintenance stages respectively.

Married men who were: educated (AOR= 4.95, 95% CI: 2.76, 8.87); in the age category of 15-29 years (AOR = 3.04, 95% CI: 1.34, 6.90); in the age category of 30-44 years (AOR = 2.06, 95% CI: 1.38, 4.55); who had at least TV (AOR = 2.42, 95 CI : 1.15, 5.08); and who had radio only (AOR = 2.27, 95% CI: 1.22, 4.23) were more likely to involve in family planning.

Conclusion and recommendation: Most of the distributions of trans-theoretical model stage of behavioral change of married men were found in pre-contemplation. Various factors like age, education and television and/or radio ownership have a significant effect on involvement of men in family planning. Thus, educating men and designing stage matched as well as men inclusive and friendly family planning programs and interventions were recommended.

Key words: Use of Modern contraception, Stages of Change, stage distributions

1. Introduction

1.1 Statement of the problem

Population growth is a global concern (1). High population growth is a main challenge to poverty reduction and development through putting pressures on already meager resources and exerting unsustainable pressure on the provision of food, housing, health and educational services, employment opportunities and other infrastructure, especially for developing countries (2) .

World Demographics Profile 2012 estimate revealed the world population exceeds 7 billion at the end of 2011 with a growth rate of 1.092% which results in about 145 net additions to the worldwide population every minute or 24 persons every 10 second. The global total fertility rate was 2.46 children born per woman (3).

Sub-Saharan Africa has the highest total fertility rate in the world. In 2009 the average number of births per woman was 5.1—more than twice as many as in South Asia (2.8) or Latin America and the Caribbean (2.2). The average contraceptive prevalence (22%) is less than half that of South Asia (53%) and less than a third that of East Asia (77%). As a result of these patterns, the region is growing at a faster rate (2.3%) than other regions of the developing world, including both Asia and Latin America (1.1% each) (4).

Ethiopia is the second most populous country in Africa, next to Nigeria. The estimated population in 1984 was 39.9 million. It took only 26 years for this to double to 79.8 million in 2010, with 2.6% growth rate (5). Contraceptive prevalence rate is low; and fertility rate still remaining high in the country: 29% and 4.8 respectively. The country faces high unmet need (25%) for family planning; of which 9% were for limiting and 16% were for spacing(6), but the MDGs plan is to reduce unmet need for FP to 5.6% in 2015 (7).

Amhara Region, the second most populous region in Ethiopia, had a population 18.7 million with the annual growth rate of 1.8% which was the lowest compared to other regions in the country (5), but still higher compared with global growth rate(3). The Region had higher CPR and lower unmet need for FP, 33.9% and 22.1%

respectively (6), compared to the national average. Dangila town administration had population of 34,014 in 2011/2, but no independent growth, fertility and contraceptive prevalence rates were determined. Therefore, similar estimates with the Region were considered for the town administration.

Access to effective contraception contributes to improved maternal health by averting disabilities and death; it is estimated that the promotion of FP, in line with national policies, could prevent about one third of maternal deaths in countries where birth rates are high. Unwanted pregnancies carry a greater risk than those that are wanted, and that women with unwanted pregnancies are less likely to receive early antenatal care or give birth under medical supervision. In addition, spacing pregnancies by at least two years increases the chance of child survival. Moreover, contraception can prevent women from seeking unsafe abortions; it thereby contributes to reducing maternal death and disability (7).

Reproductive health in its broader sense and FP in particular should be a concern for all not for just that of women and it needs the attention of men, entire family and the society at large. However, women carry a disproportionate amount of responsibility for RH matters including FP particularly in developing countries. Although women receive the bulk of RH services, gender dynamics can render women powerless. Men often have higher decision making power in matters such as sexual relations, family size, and seeking health care than women. And this could not be different in the study area (8).

Therefore, it is crucial to support equitable partnerships between men and women while offering men services including FP services that enable them to share the responsibility for RH particularly in fertility regulation and in their family life in the sphere of marital life. As far as my knowledge is concerned, there is no TTM based study particularly about status of men involvement in FP in the selected study area in particular and in Amhara Region in general. So this research bears to address it. In addition, this assessment is invaluable to determine the behavioral change stage distributions of married men in FP and to recommend stage matched FP interventions based on the TTM five stages constructs finding in the study area.

1.2 Literatures review

1.2.1 **Fertility and Family Planning**

Nearly 400 million women in developing countries use FP methods. In the past 30 years, fertility has dropped from an average of about six children per woman to about four today, while the percentage of couples using contraception has risen from less than 15 to over 50% (9). Contraceptive use among married women of reproductive age increased in all regions of the developing world, reaching 66% in Asia and 73% in Latin America and the Caribbean in 2000–2005 (10). Evidences show that in Eastern African countries women who were using a modern contraceptive method increases from 16% in 1986 to 33% in 2007 showing an average annual increase of 1.4 percentage points; and in western Africa, it increases from 7 to 15% in the specified years(11).

The contraceptive prevalence rate in Ethiopia is less than one third. The most commonly known methods of FP include pill, injection, male condom, Norplant, and IUD. FP method for birth spacing was found highly practiced than for limiting. The most commonly used methods were injectables and pills whereas some short acting methods like condom and most long acting and permanent methods including vasectomy were poorly utilized for contraception (6).

1.2.2 Awareness/Knowledge of men about FP

A study in Turkey revealed 92% of men approved of FP, but only 54.4% actually used any contraceptive methods; 66.7% of the men said that the decision should be a joint one, 66.4% wanted to limit their family size (12). A study in Nigeria reported men possessed adequate knowledge of modern FP methods; and men's attitude toward and practice of modern FP methods was fair. However, level of spousal communication about FP and the role of men in initiating discussions about contraceptive use were poor(13).

Many studies in Ethiopia showed that men have high level of awareness about FP. A study in Hossana in 2003/4 revealed that about 91% of currently married men were familiar with at least one of the FP methods (2). A study in Wolaita Soddo in

2008/9 showed that 96% of the married men were familiar with at least one FP method which was high prevalence of awareness of contraceptive methods among married men, but low utilization of male methods (14). Studies in Gondar in 1993 and 1995 report nearly two-third of men knew at least one method of FP (15, 16).

1.2.3 **Men Involvement in FP and Fertility Regulation**

Historical decisions to exclude men from contraceptive decision-making may place the 'burden' of contraception on women and may preclude the productive involvement of men (17). Despite, Contraception is a crucial human right for its role on health, development and quality of life, equally for both men and women; and the participation of men in contraception interventions to control population growth has of great importance.

Contemporary research findings revealed that men's knowledge and attitude about FP influence women's choices and practices. Fertility and FP researches and programs have ignored men's roles in the past, focusing on women (13). Despite, recent studies have showed that men want to know more about RH and want to support their partner more actively (18). An important step in improving women's RH is the involvement of men (19). The methods of contraception for use by men include condoms and vasectomy. Worldwide, none of these "male methods" accounts for more than 7% of contraceptive use although uptake varies considerably between countries (20).

Men, in the developing world particularly in sub-Saharan Africa, are often the primary decision-makers about family size and use of FP methods. Therefore, male involvement in FP matters. The challenge of increasing men's involvement in FP is to identify the messaging that will most effectively encourage their involvement (21). Not surprisingly, African men generally desire larger families than do their wives. Many researchers agree that an ideal approach to FP involves joint decision making in the sphere of marital life (22-25). Moreover, FP adoption is likely to be more effective for women when men are actively involved that helps as an instance of behavior change in contraceptives utilization (26).

A study from southwest Nigeria showed that men have a significant role to play in the adoption of contraception. About 37% of the respondents reported joint decision making on when to have another child, 40.8% on whether to stop having children, and 44% on what to do to stop childbearing (19). Another study in Nigeria showed that 89% of men approved of the use of FP; however, spousal communication about FP and other family reproductive goals was quite poor. As a result, it was concluded that male involvement in FP decision making was poor and their patronage of FP services was low (13).

A study in Ethiopia, Hossana town, revealed that men in general wanted a greater number of children, and greater family size preferences (ideal family size) than their wives/partners in the town. Despite, nearly half (48%) of men reported current use of contraceptives by their wives (2); however, FP methods that require male involvement, such as condoms, periodic abstinence, withdrawal and vasectomy were less utilized in Ethiopia (24). Another study in Ethiopia, Wolaita Soddo, reported that about 77.5% of study participants approved use of contraception, and about 60% of study participant discussed the issue of FP (14).

A comparative follow up study for one year between husband-wife receiving counseling and counseled alone in Ethiopia, North Gondar, revealed an increase in contraceptive use, compared to women who were counseled alone. It was also reported that male-involvement not only helps in accepting a contraceptive, but also in its effective use and continuation (15). Another study in Gondar indicated 61% of men knew at least one method of FP and 64.3% of them approved the use of FP; and 41% of these said that only women should use contraception. Involvement of couples on the choice of FP methods and desired number of children in the family was approved by 58.3% of men. Half of the men did not support nulli-parous women of any age using contraception. Only 23.9% of married men have discussed FP with their wives (16).

1.2.**4 Men Behavior Change Staging Algorithm in modern FP methods**

Up to my knowledge is concerned, there were very few studies conducted with an application of TTM in the areas of FP throughout the world. A study in rural Vietnam,

using TTM, found that men involvement in FP with a staging algorithm (IUD) identified 25.8%, 7.5%, 3%, 3%, and 60.7% of the men were in pre-contemplation, contemplation, preparation, action, & maintenance stages respectively (27, 28).

A study conducted in Southern Ethiopia using TTM about men involvement in FP method use reported that about 26.7%, 7.8%, 4.5%, 16.1%, and 49.4% men were in pre-contemplation, contemplation, preparation, action, and in maintenance stages respectively (14). Almost two third of the behavior of men was in maintenance / action stage in both studies.

1.2.5 Factors that influence male involvement in FP

Several studies around the world explored many factors that influence male involvement in FP. A study from Vietnam found men who have accepted IUDs for contraception were almost two times more likely to have a son in the family than those who have not. Contraceptive behavior is influenced by the dyadic relationship between couples (26). A study from India showed that current use of contraceptives was significantly associated with inter-spousal discussion (29). Another study finding from India also provides evidence of a strong positive impact of spousal communication on contraceptive use (30). A study finding from Iran reveals that there is a significant relationship between the level of education and FP method use in such a way that when the level of education of the husband is lower, using the FP method also decreases (9).

Study results from southwest Nigeria showed that communication between a husband and wife on reproductive matters was recognized as a factor that may influence male participation in FP(19).

A study in Wolaita Soddo revealed that involvement of men in modern contraceptive use is affected by education, exposure to media, and spousal communication. It also showed that approval of men in contraceptive use was highly associated with current use of contraceptive. In addition, it indicated that men who had discussions with their wives about FP matters were four times more likely to practice FP method than men who had no discussion. Yet, FP methods use among married men was very low e.g. condom use was only nearly two percent (14). A study from Gondar also showed

educational status was positively associated with higher awareness, favorable attitude and practice of FP (16). An increase in educational attainment and wealth quintile leads to an increase in the level of contraceptive acceptance and a decrease in fertility preference (6).

1.2.6 **Trans-Theoretical model stages of change**

Trans-Theoretical Model, also known as the Stages of Change, is one of the common individual oriented health behavior change models in health education and health behavior. Theories of individual health behaviors focus on variables *within individuals* that influence their health behavior and response to health promotion and education interventions. TTM was developed in the late 1970s and 1980s and matured in the 1990s. It is a model of intentional change that focuses on the decision-making abilities of the individual rather than the social and biological influences on behavior as other approaches. TTM has several advantages over other Models. First, it describes behavior change as a process, as opposed to an event. Then, by breaking the change process down into stages and studying which variables were most strongly associated with progress through the stages. The model provides important tools for research and intervention development individualized, stage-matched, expert system interventions that target those variables most predictive of progress for individuals at each stage of change. Generally, TTM is the processes of change that drive movement through the stages of change. It is an individual oriented model departs substantially from many other individually oriented models of health behavior by focusing more on changes in behavior **(31)**.

Stages of Change: All individuals do not change their behavior at once; they change their behavior incrementally or step wise in stages of change. The most commonly considered stages across research areas include pre-contemplation, contemplation, preparation, action, and maintenance **(31)**.

Table 1: Trans-theoretical Model stage of behavioral change Constructs (pre-contemplation, contemplation, preparation, action, & maintenance)

Constructs: Five Stages of Change	**Descriptions**
Pre-contemplation	No intention to take action within the next 6 months
Contemplation	Intends to take action within the next 6 months
Preparation	Intends to take action within the next 30 days and has taken some behavioral steps in this direction
Action	Changed overt behavior for less than 6 months
Maintenance	Changed overt behavior for more than 6 months

Stage Distributions: TTM model stages of change were a stage model that shows stage progress over a twelve month period. If interventions are to match the needs of entire populations, we should know the stage distributions for specific high-risk behaviors. The most common application involves TTM-tailored expert system communications, which match intervention messages to an individual's needs across TTM constructs. A major theme is that programmatically building and applying the core constructs of TTM at the individual level can ultimately lead to high-impact programs for enhancing health at the population level.

Therefore, TTM is preferable to determine the contraceptive method utilization in accordance with the community stage of behavior**(31)**.

1.3 Justification of the study

Many studies revealed that men have greater fertility desire than women. However, most FP method options are female oriented and most FP programs give less attention to male involvement particularly in men dominated societies like Ethiopia. Similarly, society in Dangila town administration and surrounding could not be different where male domination is rampant.

It is crucial to make an investment on men involvement in FP either to use the contraceptives by themselves or to encourage and support their partners to increase the contraceptive uptake and thereby regulate fertility in the sphere of marital life. To deal with such issues, research based FP interventions are an appropriate means for effective fertility regulation. Especially, determining their stage distributions of behavioral change as criteria for audience segmentation; and thereby conducting stage matched interventions are not only effective but also efficient interventions to bring positive behavior change for effective fertility regulation. These can be applied by using the individual oriented behavioral change model called TTM stages of change that can direct tailored expert system communications across its five stages constructs.

Therefore, this research intends to assess status of men involvement in FP using TTM stages of change for determining their stage distributions; and recommend stage-matched interventions for all concerned bodies particularly for FP service providers. Moreover, the findings could serve for policy makers, planners, decision makers, practitioners, community members and other stakeholders to make research based interventions to improve FP services.

Besides, since there was a shortage of similar studies conducted in the study area in particular and in Amhara Region in general. The study findings may provide invaluable information and serve as a base line for further studies in the Region.

2. Objective of the study

2.1 General objective

- To assess status of men involvement in family planning and associated factors by using of trans-theoretical model stages of change

2.2 Specific objectives

- To determine status of men involvement in family planning
- To determine Trans-Theoretical Model stage distributions of behavior change in modern family planning methods.
- To identify factors associated with men involvement in family planning

3. Methods and subjects

3.1 Study design

A community based quantitative cross sectional study design was employed.

3.2 Study area

This study was conducted in Dangila town administration. The town was one of the 3 town administrations in Awi zone; and one of the 38 town administrations in Amhara Region. It is located 78 km from Bahir dar to Southwest direction and 485 km from Addis Abeba to the Northwest direction. The town is bordered by Dangila rural woreda Kebebes namely Zelesa in East, Wondaita kinin in West, Quanindsha in South, and Degesta Warikit in North. The town administration has an area of 9,320 sq.km; and consisted of 10 kebeles (5 urban and 5 rural) with a total population of 34,014 (24, 252 urban, & 9,762 rural) in 2011/2 based on the projection of 2007 census, of which 17, 486 (51.4%) were male. Estimated number of households based on the 2007 census conversion factor was about 7,910. There were 1 health center and 5 health posts in the town catchment.

3.3 Data collection period

The data were collected from March 26 to April 15, 2012

3.4 Source and study population

3.4.1 Source population

The source population comprises of those currently married men aged 15-59 residing in the study area.

3.4.2 **Study population**

The source and study populations were those currently married men aged 15-59 years and lived in the study area for at least six months prior to the data collection.

3.4.2.1 **Inclusion criteria**

- Currently married men (15-59 years old) who lived in the study area for more than six months prior the data collection
- Married men who had lived with their wives during the past six months prior to the data collection
- Currently married men whose wives were in the child bearing age (15-49 years) and not pregnant during the study period; and who did not plan to get his wife pregnant in the next 6 months after the data collection.

3.4.2.1 **Exclusion criteria**

- Married men who had severe health problem such as bed driven that had difficulty to talk, hear, …

3.5 Sample size determination and sampling procedures

3.5.1 **Sample size determination**

The required sample size was determined by using a single population proportion formula. The formula used for calculating the sample was:

$$\mathbf{n} = \frac{(Z_{\alpha/2})^2 p(1-p)}{d^2} = \frac{(1.96)^2 X\ 0.6(1-0.6)}{(0.05)^2} = 369$$

Where,

- ✓ n = The desired sample size
- ✓ p = Proportion of currently married men who discussed about the issues of family planning (60%) (14)
- ✓ $Z_{\alpha/2}$ = Critical value at 95% confidence level of certainty (1.96)
- ✓ d = The margin of error to be tolerated between the sample and the population = 5 %

Considering non response rate of 37(10%), the total sample size for the study was 406 currently married men. Then proportional sample allocation ratio was used to get the samples from each stratum (Kebeles).

3.5.2 **Sampling Procedure**

All kebeles of Dangila town administration were considered for sampling. The woreda was stratified into kebeles. The sampling fractions from each kebele were determined by probability proportional to the size of the total population of each stratum (kebele) from the total population of the town administration (target population). Sampling units (households that fulfill the inclusion criteria) were selected using systematic random sampling after stratifying the town administration into kebeles. The center of the each kebele was considered for the beginning. The direction to start was chosen by spinning ball-pen on smooth ground, and the tip indicates the direction to start the survey. Then the first household was selected by lottery method after counting from 1 to 19 (K). The next household in each kebele was identified by systematically every 19^{th} interval by walking in a clockwise direction. When more than one respondent were found in the selected household, only one respondent was chosen by lottery method. In cases where there was no eligible interviewee/respondent in the selected household, a next household was visited. Repeated visits were conducted while the respondents were absent (Fig 1).

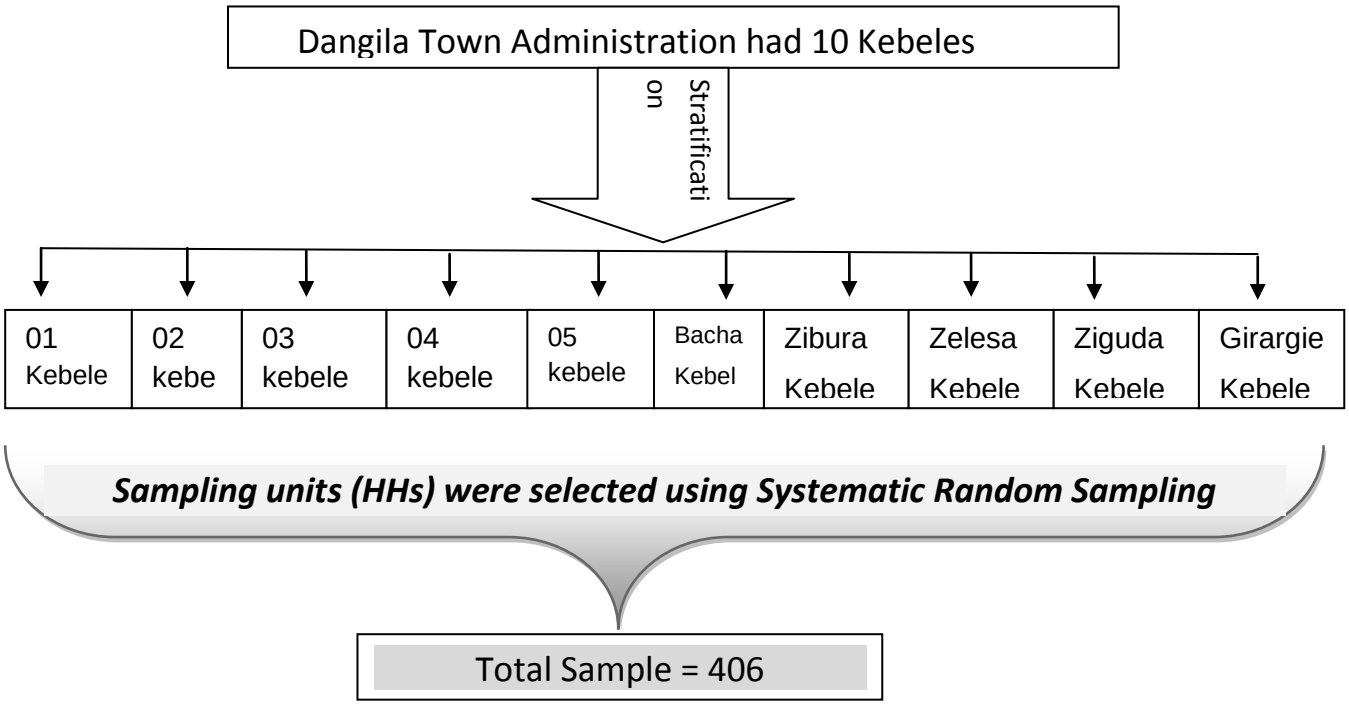

Figure 1: Schematic Representation of Sampling Procedures, Dangila town administration, Amhara Region, Ethiopia, 2012

PPA = proportional sample allocation

3.6 Variables of the study

3.6.1 **Dependent variable**

- ✓ Status of men involvement in FP

3.6.2 **Independent Variables**

- ➢ Socio- demographic characteristics:
- Age, educational status, residence, occupation, religion, and ethnicity of the respondent
- Age and educational status of respondent's wife
- ➢ Reproductive health characteristics: age at first marriage, ever born children, current living children, and desired number of children of the respondent
- ➢ Awareness of modern FP methods, source of information

3.7 Operational definitions

Approval of modern FP Method: those respondents who were giving an agreement (acceptance) to himself and/or his wife for current use of modern FP method to limit or space the number of children.

Current use of modern FP method: those respondents or their wives who were using modern FP method to limit or space the number of children during the period of data collection.

Ever use of modern FP method: those respondents or their wives who were using contraception once in their life. It includes those who were using modern FP methods during the data collection period.

Educated: those who had educated at primary and above level (formal education)

Husband-wife communication about FP: those respondents who have made a discussion with their wives about FP issues such as spacing, limiting, contraceptive methods choice and use at least once within the previous month prior to the period of data collection

Men Involved in FP: Those respondents who were participating at least in either of the following: Communicating about FP with their wives within the previous month at least once prior to the period of data collection and/or; using modern FP method either by the respondents themselves or their wives after getting the respondents approval during the period of data collection.

Awareness of modern FP method: recalling at least one modern contraception method that can be used to limit or space the number of children.

Uneducated: Those who had no formal education which included those who couldn't read and wrote; and those read and wrote (no formal education)

3.8 Data collection procedures

3.8.1 Data collection techniques and tools

The data was collected by face-to-face interview (house-to-house) using a pretested structured questionnaire. The questionnaire was prepared first in English then translated into Amharic. The Amharic version questionnaire was pretested for clarity, acceptability, and flow. Based on the findings from pretesting, the questions with certain ambiguity were modified; and the corrected questionnaires were distributed to the data collectors to collect the data.

3.8.2 Data collection procedures

Five final year male health science students from Dangila Andinet Health Science College was selected and recruited for data collection. Two BSc health professionals from Dangila health office were recruited and trained to act as supervisors. The data collectors and supervisors were well trained and oriented to act effectively as required in their respective responsibilities. The questionnaire was pre-tested among 5% married men in nearby kebeles' of dangila rural woreda (bordered kebeles). All possible efforts were made by data collectors, supervisors, and investigator to maintain consistency and completeness of data.

3.9 Data quality Assurance

The data quality was maintained by pre-testing the questionnaire, selection and training of appropriate field staff (data collectors and supervisors), and strengthening

supervision and close monitoring during the data collection. The questionnaire was first prepared in English then translated into Amharic (by principal investigator), and back translated into English (by a language expert). The completeness and consistency of data were checked first by data the collectors, then by supervisors and finally by the principal investigator. Double entry at least 10% of the questionnaires was conducted after data entry to check a consistency.

3.10 Data processing and analysis

This data was cleaned and coded before it was entered into computer. Data entry was done using Epi-Info version 2002 template. Descriptive analysis like frequencies and percentage of different variables such as measure of central tendency such as Arithmetic mean and measure of dispersion such as standard deviation and range were computed for description. Crude and adjusted odds ratios with 95% CI were computed using SPSS version 16.0.

3.11 Ethical considerations

Ethical clearance was obtained from the Institute of Public Health, University of Godar; and supportive letter was obtained from ANRS Health Bureau. Both written and verbal permissions were secured to undertake the study from the Dangila town administration health office. Then official letter was written and dispatched to each kebeles. All the study participants were informed about the objective and importance of the study; and their verbal consent was obtained before conducting the data collection. They were also informed about their right of not participating in the study at any time. Privacy and confidentiality of the information were assured and collected anonymously throughout the entire study period.

3.12 Dissemination of results

The final report of the study will be submitted, presented and discussed in University of Gondar, Institute of Public Health. Results of the study will be disseminated to health office of the study area as well as to the ANRS Health Bureau and other relevant organizations who are working around sexual and RH matters. In addition,

all possible efforts will be made to present at professional association meetings, conferences and to submit for scientific publications.

4. Results

4.1 Socio-demographic Characteristics

All study participants responded to the questionnaire making the response rate 100%. 291(71.7%) of them were from urban kebeles. The ages of the study participants were ranged from 15 to 59 with an average age of 37.56±9.06 years. 228(56.2%) of the study participants were in the age range of 30 – 44 years. And 228(56.2%) of them were Agew, the rest 178(43.8%) were Amhara in ethnicity. Majority of the respondents' religion were Orthodox (Table 2).

Two-third of the study participants had received formal education. More than half of them were farmer and government employed? Nearly eight per ten of them had owned radio and/or TV. And about 80.5% of them reported that they had made a joint decision with their wife on their household wealth and asset (Table 2).

Table 2: Socio-demographic characteristics of currently married men (N=406), Dangila Town Administration, Amhara Region, Ethiopia, 2012.

Variables	Category	Frequency	Percent (%)
Residence (kebele)	Urban	291	71.7
	Rural	115	28.3
Age (Year)	15-29	82	20.2
	30-44	228	56.2
	45-59	96	23.6
Ethnicity	Agew Awi	228	56.2
	Amhara	178	43.8
Religion	Orthodox	359	88.4
	Muslim	34	8.4
	Protestant	13	3.2
Educational status	Uneducated	138	34.0
	Primary	73	18.0
	Junior	81	20.0

Variables	Category	Frequency	Percent (%)
Occupation	More than Junior	114	28.1
	Farmer	121	29.8
	Government Employed	111	27.3
	Merchant	91	22.4
	Daily Laborer	88	20.5
Radio and/or TV ownership	Radio only	160	39.4
	TV only	74	18.2
	Both Radio and TV	82	20.2
	None	90	22.2
Main decision maker on the household wealth and asset	Both respondent and his wife	327	80.5
	Respondent only	71	17.5
	Respondent's wife only	7	1.7
	Respondent's parent	1	0.2

4.2 Reproductive health Characteristics

The study participants were married at an average age of 24.03 ± 5.41 years old. 103(25.4%) of them were married at the age of 20 and below years old. And 275 (67.7%) of the respondents were married when they were with the age range from 21 to 30 years old. The rest 28 (6.9%) were married when they were above 30 years old. The study participants had stayed within marriage on average for about 12.08± 8.39 years. 209 (51.5%) of them were stayed for less than 10 years within it. And 135 (33.3%) of them were stayed with their marriage from 21 to 30 years long. The rest 62(15.3%) were stayed for a length of more than 20 years. 365(89.9%) of the participants have children whereas the rest 41 (10.1%) had not.

The study participants had their first child when they were at average age of 26.37 ± 4.76 years. Almost two-third of them had their first child when they were less than 30 years old. The average number of ever born and currently living children was 3.4 and 3.2 respectively, and the average desired number of children was 4.2. More than seventy percent of the study participants desire to space their next birth with at least two years (Table 3).

Table 3 : Reproductive health characteristics of the study participants, Dangila Town Administration, Amhara Region, Ethiopia, 2012

Variables	Category	Frequency	Percent (%)
Age at first having a child (Years)	15-29	271	66.7
	≥ 30	94	23.2
	No child	41	10.1
Ever born children	No child*	41	10.1
	1-2	153	37.7
	3-4	117	28.8
	≥5	95	23.4
	No child**	46	11.3
Current living Children	1-2	159	39.2
	3-4	118	29.1
	≥5	83	20.4
Desired number of children	1-2	84	20.7
	3-4	196	48.3
	≥5	126	31.0
Desired birth spacing	< 2 year	30	7.4
	2- 5 year	145	35.7
	≥5 year	145	35.7
	Don't know	62	15.3
	No need of more child	23	5.7
	As will of God	1	0.2

* includes those who had not born a child; ** include both who had not born a child & who loss (died) their child;

4.3 Awareness about modern FP methods

399(98.3%) of the respondents had heard about modern FP methods. The most commonly mentioned modern FP methods were injectables 348(87.2%), condom

334 (83.7%), pills 321(80.5%), Implants 202(50.6%), IUD 80(20.1%), Vasectomy 30(7.4%), and Tuba-ligation 22 (5.5%). HEWs and radio were the main source of modern FP method information for more than two third of the study participants (68.9% and 64.9% respectively). 334 (83.3%) and 30(7.4%) of the study participants had aware about condom and vasectomy respectively (Table 4)

Table 4: Awareness of study participants (N=406) about modern contraceptive methods, Dangila Town Administration, Amhara Region, Ethiopia, 2012

Variables	Category	Frequency	Percent (%)
Ever heard about modern FP method	Yes	399	98.3
	No	7	1.7
Specific modern FP method mentioned (N=399)*	Injectables	348	87.2
	Condom	334	83.7
	Pills	321	80.5
	Implants	202	50.6
	IUCD	80	20.1
	Male sterilization	30	7.4
	Female sterilization	22	5.5
Source of information (N = 399)*	HEWs	275	68.9
	Radio	259	64.9
	Other Health professionals	152	38.1
	Television	140	35.1
	VCHWs	32	8.0
	Others**	15	3.8

*Multiple responses were given about Awareness of each method and source of information; ** includes: Friends (7), wife (3), school (2), books (1), Mahiber (1), & Magazines (1)

4.4 Husband-wife Communication about FP and modern contraceptive utilization

357(87.9%) of the study participants were discussed about FP with their wives in the last year. 229(56.4%) of them were discussed about it in the last month at least once, and birth spacing 143(62.4%) were mainly the topic of the discussions. 107(26.4%) of the study participants were ever requested to use male methods by their wives; and 95(88.8%) of the requested participants were approved to use the method (table 5).

The study participant who were disapproving, 12(12.2%), their ever request had reasons like fear of side effects (57.2%), respondent refusal (49.7%), cultural (24.5%) and religious (19.5%) reasons.

The study participants were again asked their approval status if they were requested to use the male methods by their wives currently. 247(60.8%) of the participants were answered to approve and with a preference of condom 228 (92.3%) and vasectomy 19(7.7%). 159(19.5%) of the study participants were responded to disapprove the current request; and their reasons were fear of side effects (91(57.2%)); they don't want (79(49.7%)); culture doesn't allow (39(24.5%)); religion doesn't allow (31(19.5%)); & wife stopped giving birth (1(0.6%)).

327(80.5%) of the study participants were ever requested by their wives to give their approval for their wives to use by themselves. 320 (97.9%) of the requested participants gave their agreement to their wives to use modern FP methods (table 5).

7(2.1%) of the ever requested participants were disapproved to their wives' modern contraceptive use. They were reasoned out like four men said I didn't want, two men said religion doesn't allow and one man said culture doesn't allow.

The respondents were also asked what would be their response if their wives ask to use modern contraceptive by themselves currently. 391 (96.3%) of them were answered they would approve for their wives request whereas the rest 15 (3.7%) were reported not approved for their wives' contraceptive use; and had reasons like

nine men said fears of side effects , four men said I don't want and 2 men said religion doesn't allow .

Table 5: Husband –wife Communication and Approval among currently married men (N=406), Dangila Town Administration, Amhara Region, Ethiopia, 2012

Variables	Category	Frequency	Percent (%)
Discussed about FP with wife in the last year	Yes	357	87.9
	No	49	12.1
Discussed about FP with wife in the last month	Yes	229	56.4
	No	177	43.6
Topics of discussion in the last month (N=229)*	Birth spacing	143	62.4
	FP methods	82	35.8
	No of children to have	69	30.1
	Limiting	38	16.6
	To be economical	2	0.9
Ever requested by wife to use male modern FP method	Yes	107	26.4
	No	299	73.6
Response for the ever request to use by himself(N=107)	Yes (Approved)	95	88.8
	No (Disapproved)	12	12.2
Ever requested by wife to use by herself	Yes	327	80.5
	No	79	19.5
Response for ever approval request for herself (N=327)	Approved	320	97.9
	Disapproved	7	2.1

*Multiple responses were possible

4.5 Utilization of Modern FP Methods

100(24.6%) of the married men were ever used male modern FP method. 71 (17.5%) of the study participants were current users of male modern FP method. All of the ever and current users were using condom (table 6).

According to the information from the respondents, nearly eight per ten (81.0%); and seven per ten (69.2%) of the respondents' wives were ever and current users of modern FP methods respectively. Birth spacing (81%) was the main reason reported by the current modern FP method users (Table 6).

Table 6: Practices of modern FP methods among married men (N= 406) and their wives, Dangila Town Administration, Amhara Region, Ethiopia, 2012

Variables	Category	Frequency	Percent (%)
Ever use of male modern FP method	Yes	100	24.6
	No	306	75.4
Current use of male modern FP method	Yes	71	17.5
	No	335	82.5
Ever use of Female modern FP method	Yes	329	81.0
	No	70	17.2
	Don't know	7	1.7
Ever used methods (N=329)*	Injectables	230	69.9
	Pills	181	55.0
	Implants	70	21.3
	IUCD	17	5.2
Current use of Female modern FP methods	Yes	281	69.2
	No	118	29.1
	Don't know	7	1.7
Husband approval for current use by wife (N=281)	Approved	267	95%
	Disapproved	14	5%
Current used method (N=281)	Injectables	149	53.0
	Pills	75	26.7
	Implants	48	17.1
	IUCD	9	2.2
Reasons for current use (respondent or his wife, N=282)*	Spacing	228	80.9
	Limiting	54	19.1

* Multiple responses were possible;

The main reasons reported by current modern FP method non-users were fear of side effects, respondents' refusal, respondents' wives' refusal, religious prohibition, cultural reasons, health problems and fear of infertility (Fig 2)

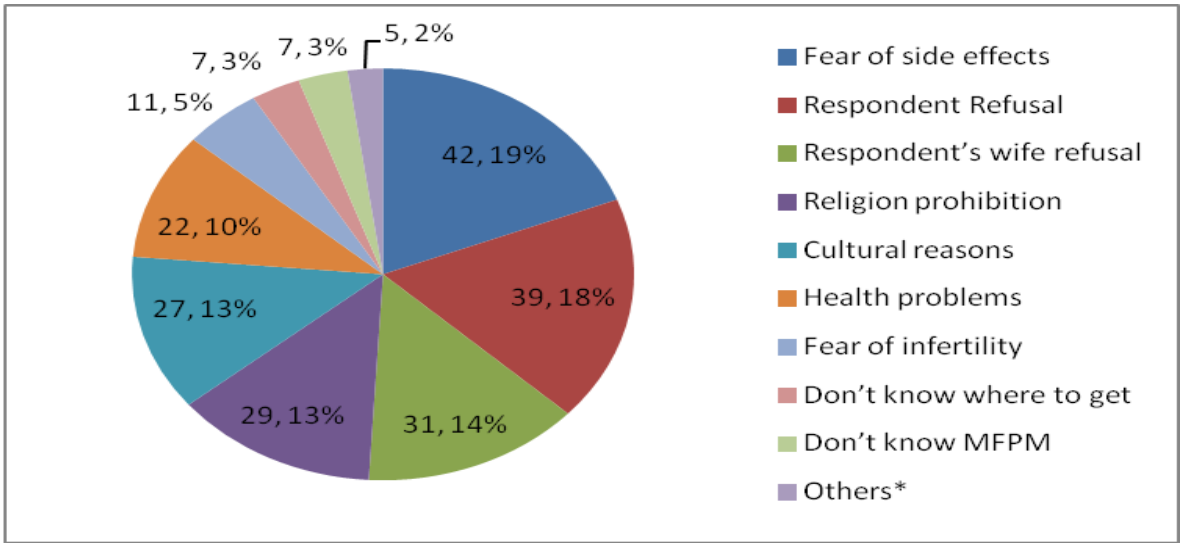

Figure 2: Reasons for current non-use of modern FP methods among married men (N= 406) and their wives, Dangila Town Administration, Amhara Region, Ethiopia, 2012

Note: Other* include wife is using (3), wife stopped giving birth (2)

4.6 Men Involvement and TTM stage distributions of behavioral change

378 (78.3%) of the study participants were involved in FP, whereas 88(21.7%) were not involved in it. Those involved were those who were participated in at least the following actions: discussed about FP in the last month at least once with wives, and/or use modern contraceptive by themselves, or /and approved to use for their wives. Those who were not participated in any of these three actions were considered as not involved in FP

This study assessed the TTM stage distributions of behavioral change in utilization of modern contraceptive among the currently married men. Seven out of ten of them had no intention to take FP method in the future (*pre-contemplation stage*). The rest 22(5.4%), 25(6.2%), 53(13.1%) and 18(4.4%) were in contemplation, preparation, action and maintenance stages respectively (Fig 3).

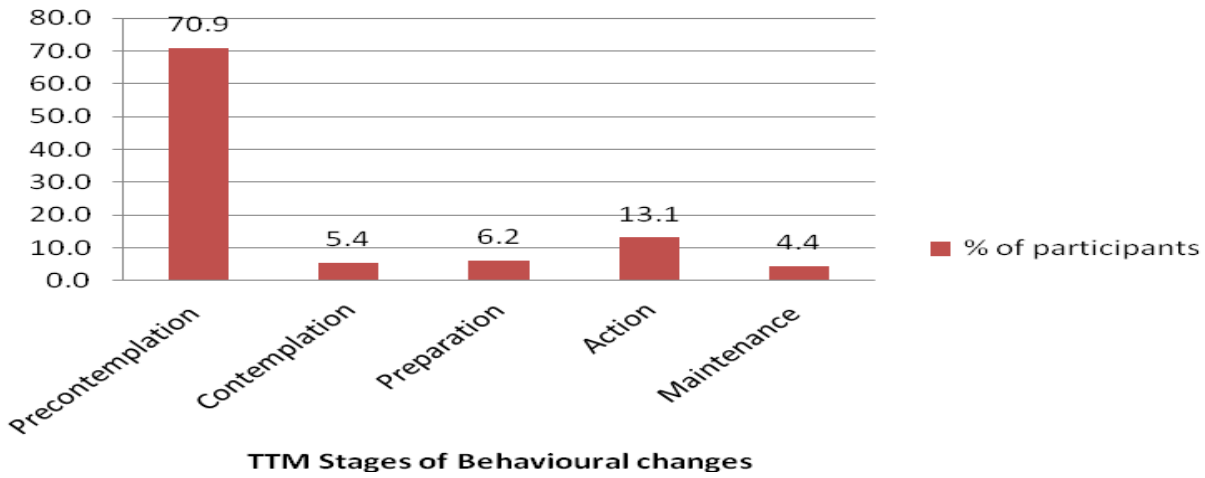

Figure 3: TTM Stage distributions of behavioral change among married men in modern family planning method use (N= 406), Dangila Town Administration, Amhara Region, Ethiopia, 2012

This study also assessed the TTM stage distributions of behavioral change among participants' wives. According the information gained from the respondents, more than half (223 (54.9%)) of the wives of study participants were using modern contraceptive in the past six and above months (maintenance stage). The rest 53(13.1%), 23(5.7%), 29(7.1%) and 73 (14.8%) were in action, preparation, contemplation and pre-contemplation stages respectively (Fig. 4)

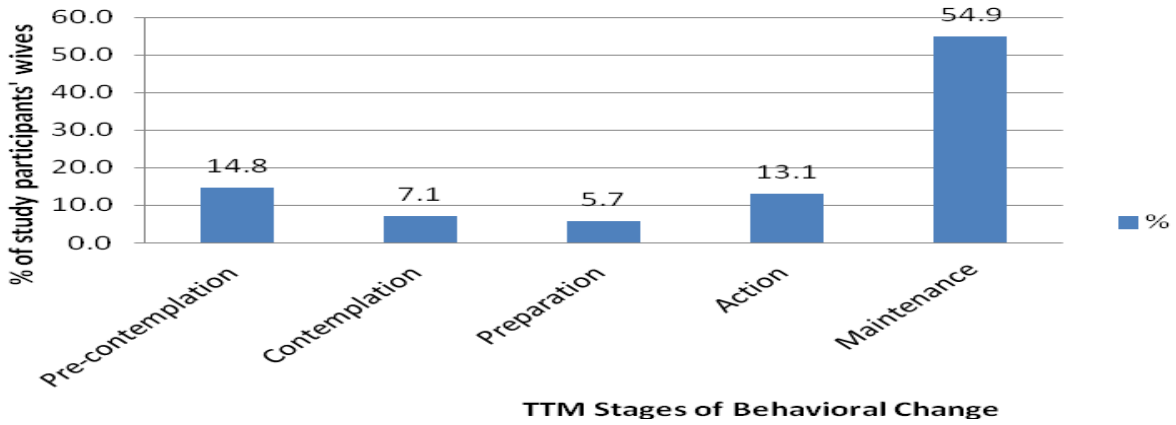

Figure 4: TTM Stage distributions of behavioral change among participants' wives in modern FP method use (N= 388), Dangila Town Administration, Amhara Region, Ethiopia, 2012

Note: The TTM stages of behavior change of respondents' wives were including those were remembered (388) by their husbands only; the rest 18 (4.4%) who were not known by their husbands (i.e. 5 (1.2%) from current FP users and 13 (3.2%) non-users) were not considered in the wives stages distributions.

4.7 Associated factors that influence men involvement in family planning

An analysis of the socio-demographic and reproductive variables in relation to men involvement in family planning was done. Odds ratio (OR) with their corresponding 95% confidence interval were adjusted for residence, respondents' (age, educational status, and occupation), respondents' wives (age and educational status), radio and/or television ownership, and currently living children. Variables like age, educational status, and TV and/or radio ownership of respondents were found to have statistically significant impact on men involvement in FP (Table 7).

Married men who were educated were 4.95 times more likely to involve in FP than their counter parts (AOR= 4.95, 95% CI: 2.76, 8.87). Married men who were in the age category of 15-29 years and 30-44 years had 3.04 and 2.06 times more likely to involve in FP when compared with those who were in the age category of 45-59 years (AOR = 3.04, 95% CI: 1.34, 6.90; AOR = 2.06, 95% CI: 1.38, 4.55) respectively. Married men who had at least TV and Radio only were 2.42 and 2.27 times more likely to involve in FP than those who had neither TV nor radio (AOR = 2.42, 95 CI : 1.15,5.08: AOR = 2.27, 95 CI: 1.22,4.23) respectively (table 7).

Variables like ethnicity and religion of respondents have no statistical association with married men involvement in FP in the bi-variate analysis result. Though, the variables like residence and occupational status of respondents, age of respondents' wives, and number of living children respondents had had statistically significant in the result of bi-variate analysis; they had come up no statistical association with men involvement in FP when adjusted in the result of multivariate analysis (Table 7).

Table 7: Results of Bivariate & Multivariate Analysis of men involvement in FP with socio-demographic & reproductive variables, Dangila Town Administration, Amhara Region, Ethiopia, 2012

Variable	Category	Men involvement in FP		COR(95%CI)	AOR(95%CI)
		Yes (%)	No (%)		
Residence (Kebele)	Urban	240(82.5)	51(17.5)	2.23(1.36, 3.66)	1.10(0.57, 2.11)
	Rural	78(67.8)	37(32.2)	1	1
Age of respondent	15-29	70(85.4)	12(14.6)	3.06(1.45, 6.42)	3.04(1.34, 6.90)*
	30-44	185(81.1)	43(18.9)	2.25(1.32, 3.85)	2.51(1.38, 4.55)*
	45-59	63(65.6)	33(34.4)	1	1
Educational status of respondent	Uneducated	80(58.0)	58(42.0)	1	1
	Educated	238(88.8)	30(11.2)	5.75(3.46, 9.56)	4.95 (2.76, 8.87)*
Occupational status of respondent	Farmer	98(88.3)	13 (11.7)	1	1
	Government employed	82(67.8)	39(32.2)	0.28(0.14,0.56)	1.06(0.28, 4.04)
	Merchant	78(85.7)	13(14.3)	0.80(0.35,1.81)	1.01(0.41, 2.47)
	Daily Laborer	60(72.3)	23(27.7)	0.35(0.16, 0.73)	0.77(0.31, 1.94)
Age of respondent's wife	15-24	85(82.5)	18(17.5)	2.26(1.17, 4.35)	0.77(0.28, 2.10)
	25-34	164(81.6)	37(18.4)	2.12(1.23, 3.66)	1.44(0.67, 3.12)
	≥35	69(67.6)	33(32.4)	1	1
Educational status of respondent's wife	Uneducated	136(68.7)	62(31.3)	1	1
	Educated	182(87.5)	26(12.5)	3.19(1.92, 5.31)	1.21(0.61, 2.39)
Radio and/or TV ownership	At least TV	136(87.2)	20(12.8)	3.94 (2.08,7.43)	2.42(1.15, 5.08)*
	Radio only	125(78.1)	35(21.9)	2.07 (1.17, 3.65)	2.27(1.22,4.23)*
	None	57(63.3)	33(36.7)	1	1
No of current living children	≤ 3	220(81.5)	50(18.5)	4.40(3.24, 5.98)	0.69(0.35, 1.35)
	> 3	98(72.1)	38(27.9)	1	1

* $p \leq 0.05$

5. Discussion

This study attempted to assesses the status of men involvement in FP in Dangila town administration, Amhara Region, Ethiopia. Involving men and obtaining their support and commitment to FP is crucial for FP service utilization. This paper focuses on the importance of involving men in influencing the utilization of FP method and highlighted the potential insights into men's behavior where FP interventions could be made. There were variations in the types of FP method that were practiced in the study area. By far the most popular modern method, used by 69.9 percent of currently married women, was Injectables. Injectable was also mentioned as a popular used method at national level (6) . Male methods such as vasectomy and condom were utilized poorly, which was consistent with study done in Hosanna (2). The respondent refusal, fear of side effects, health concern, cultural and religious prohibition were among the reasons reported for none using of modern FP methods in the study area.

In this study, 98.3% of married men were aware at least one method of modern FP methods. This finding was in nearly consistent with national figure that stated as awareness of contraception is nearly universal in Ethiopia(6). The high awareness about modern FP methods in the study might be due to FP interventions by the health sector including the implementation of the innovative urban and rural health extension programs, national and international organizations, and increased exposure to education.

This study finding showed that about 87.9% and 56.4% married men discuss the issue of FP with their wives at least once in last year and month prior to the data collection respectively. This was found higher compared to previous studies done in different parts of Ethiopia (14, 16). This might be due to time variation; and an increased awareness of the community about modern contraception, increased access to FP services especially through urban and rural health extension programs. Male method of contraception (condom) was found higher practiced by the study participants in the study area than the national average. There was no man in the

study participants that undergone Vasectomy which was a consistent finding with a study done in Wolaita Soddo (14).

The average numbers of living and desired children per men were 3.2 and 4.2 respectively. The average number of living children was lower than studies done in Gondar and Wolaita Soddo. However, the desired number of children was found lower than a study done in Gondar but somewhat higher than a study done in Wolaita Soddo (14) . This could be explained by high awareness of FP by the study participant and improvement in practice of FP method. In addition, it could be due the time variation.

The current use of condom among study participants were found 17.5% which was in line with a study done in Iran (18%) (1) . However, this result was higher than a study done in Hosanna (2). This may be due to time variation. The time may have an opportunity to bring a certain change as further interventions could be undertaken within that time variation.

Overall, the prevalence of men involvements in FP among the study participants was found about 78.3 percent. The prevalence of men involvement among married men (population proportion) was estimated to be found within 74.3% and 82.3% with 95% confidence level. This finding was higher than a study done in Wolaita Soddo (14). This difference may be due to measurement difference between the two studies. This study assess the status of men involvement in FP which were include married who had conducted discussion about FP within the previous month, and/ or they themselves use modern male contraceptives; and/ or those who approved to the current use of their wives. However, the study done in Wolaita Soddo was dealt only with FP method use.

No one in the study group or his wife was undertaken sterilization. Only less than 8 percent of the study participants knew the permanent modern FP methods (both male & female sterilization) in the study area. However, nineteen study participants were preferred to use vasectomy if they were requested by their wives currently. This might be due to a deficient of permanent FP method interventions in the study

area. Another possible reason may be unavailability of the services in the study area.

More than seventy percent of the study participants desire to space their next birth for at least two years. Only nearly one per ten participants desires to space their child birth with less than two. This finding was found in agreement with a study done in Ethiopia (14, 16). As spacing pregnancies by at least two years increases the chance of child survival (7); this finding is taken a good news to the population of the study area.

The study participants were asked to respond the behavioral stages of their own and their wives separately. The results were 70.9%, 5.4%, 6.2%, 13.1% and 4.4% of the married men were in pre-contemplation, contemplation, preparation, action and maintenance stages respectively. The study participants also reported that 14.8%, 17.1%, 5.7%, 13.1% and 54.9% of their wives were in the pre-contemplation, contemplation, preparation, action and maintenance stages respectively. This showed better modern FP method utilization behavior among women than men. This may revealed a disproportionate amount of FP interventions among men and women in the study area.

Since this study deals with the study participants by asking their own and their wives behavioral stages separately and about modern FP utilization only; it was come up with a different stage distributions when compared with studies done in developing countries (14, 27).

In addition, when we compare the respondents' behavioral stage distributions with their wives, it was found with contrary results particularly in stage of pre-contemplation and maintenance. Most of the married men were found in pre-contemplation stage; yet, most of the respondents' wives were in maintenance stage.

Married men who were found in p*re-contemplation* stage did not intend to take action in the near time, usually measured as the next six months after the period of data collection. This may be due to limited method mix (contraceptive menu) for males or less programmatic attention given to men in the FP programs. This was

supported by previous studies that most FP method options are female oriented and most FP programs give less attention to male involvement particularly in men dominated societies like Ethiopia(8). In addition, they may be in this stage because they were uninformed or under-informed about the consequences of their behavior. Another alternative explanation could be the traditional health promotion programs were not ready for such individuals and were not motivated to match their needs. It may be also due to absence of male oriented/ men friendly/ FP services. In addition, the role of cultural and religious influences may not be ignored in this regard **(31)**.

However, it is crucial to support equitable partnerships between men and women while offering men services including FP services that enable them to share the responsibility for RH particularly in fertility regulation and in their family life in the sphere of marital life. Otherwise, historical decisions to exclude men from contraceptive decision-making may place the 'burden' of contraception on women and may preclude the productive involvement of men (17).

In this study, we can classify both the study participants and their wives as those who were in different behavioral stages like in pre-contemplation; contemplation and preparation stages were those who were currently not practiced their respective modern FP methods. And, those who were in action and maintenance stages were those who were currently practiced their respective modern FP methods.

This study revealed that those married men who had educated more likely to involve in FP than those who were uneducated. It could be stated as education has a strong positive association with men involvement in FP. This finding showed that there was strong association between educational attainment and men involvement in FP. The finding was consistent with various studies conducted in Ethiopia (6, 9 &16). The possible justification could be education forebear’s modern ideas of small family size as it means better standard of living. It also ensures greater awareness about various methods and their effectiveness.

Married men who were in the age category of 15-29 and 30-44 years have more likely to involve in FP when compared with those who were in the age category of 45-59 years which have strong and moderate positive association respectively. This

showed that an increase in age leads to a decrease in men involvement in FP (chi-square for trend test, $X^2 = 10.683$, $p = 0.001$). This may be justified as married men who were in the earlier age groups may involve in FP as they are engaged in other priorities such as learning. However, for better explanation it may need further studies using more powerful study designs such as follow –up studies.

HEWs and radio were the main source of modern FP method information for the study participants. It also found that married men who had at least TV and radio only were more likely to involve in FP than those who had neither radio nor TV. Both having at least TV and radio only have moderate positive association. This finding was in agreement with a study done elsewhere in Ethiopia (14) . This may be because of media influences the awareness, knowledge, attitude and practice of the study participants.

The number of children that married men has no statistical association with their involvement in FP. This finding was nearly similar with the study participants' desired number children which was 4.2. Therefore, this association might be as a result of married men having already desired number children.

Residence of respondents has no statistical association with men involvement in FP. This may explained due to their similar life style and cultural commonness among study participants.

The information on income was excluded from the analysis because of its incompleteness, which could be limited the incorporation of income as a possible confounder for the findings.

6. Limitation of the study

- Assessment of TTM stage distributions of behavioral change could be more appropriate in follow up (intervention) studies. The changes in behavior over time after an intervention study could have more clarity. In spite this fact, our study, which was a cross-sectional study, could only show about baseline (current status) of the study participants.
- The identified factors for men involvement in family planning do not show causal relationship, since the study was cross-sectional too.
- Social desirability bias could not be ruled out while respondents respond to the questions. They could give perceived desirability of responses rather than their actual awareness or practices which could introduce response biases
- As with all cross-sectional surveys, this study was not free from response and recall biases. Respondents' responses to questions related to practices in the past (responses such as ever use of modern contraceptive method by themselves or by their wives) were subjected to recall bias.

7. Conclusion

Even though the overall involvement of married men in FP was found a promising in the study area [78.3% (95% CI: 74.3% - 82.3%)]; it was found a low utilization of male methods of modern FP. There was no man in the study participant that undergone vasectomy. Most of the married men were found in pre-contemplation TTM stage of behavioral change. On the contrary, most of their wives were found in maintenance TTM stage of behavioral change. Various factors like age, education and TV and/or radio ownership have a significant effect on involvement of men in FP. This finding was found that married men, who were younger, educated and having either radio or TV or both have more likely to be involved in FP when compared to their respective counter parts.

8. Recommendations

Based on this study finding the following recommendations are made for all stakeholders who are working in fertility and population regulation in general and the specified organizations in particular to ensure men involvement in family Planning.

A. To Health sectors and its partners and stakeholders

- Most married men are found in the pre-contemplation stage distribution of behavioral change. This stage matched FP interventions (matched to each individual's stage of change) like consciousness raising, dramatic relief, and environmental reevaluation need to be designed and implemented/applied to change their behavior
- Designing men inclusive and men friendly family planning programs and interventions are needed to ensure men involvement in family planning in general, and to increase utilization of the available modern male methods of family planning in particular.

B. To education sector and its partners and stakeholders

- This study finding, as many other findings, comes up with a fantastic tip point that could assure 'education matters men involvement in FP'. Therefore, more efforts need to be attempted in order to increase men school enrollment (educating men) as it influence for their better involvement in FP which directly contribute to fertility and population regulation.

C. To researchers

- This study focuses only on constructs of stage distributions of the behavioral change of men, therefore further study was recommended to conduct by using other constructs of TTM like self efficacy, decisional balance (cons & pros), and process of change via follow up study designs triangulating with qualitative study.
- This finding showed an increase in age leads to an increase in men involvement in family planning. Further studies using more strong study designs are recommended.

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10. Annexes

Annex 1: Conceptual Framework

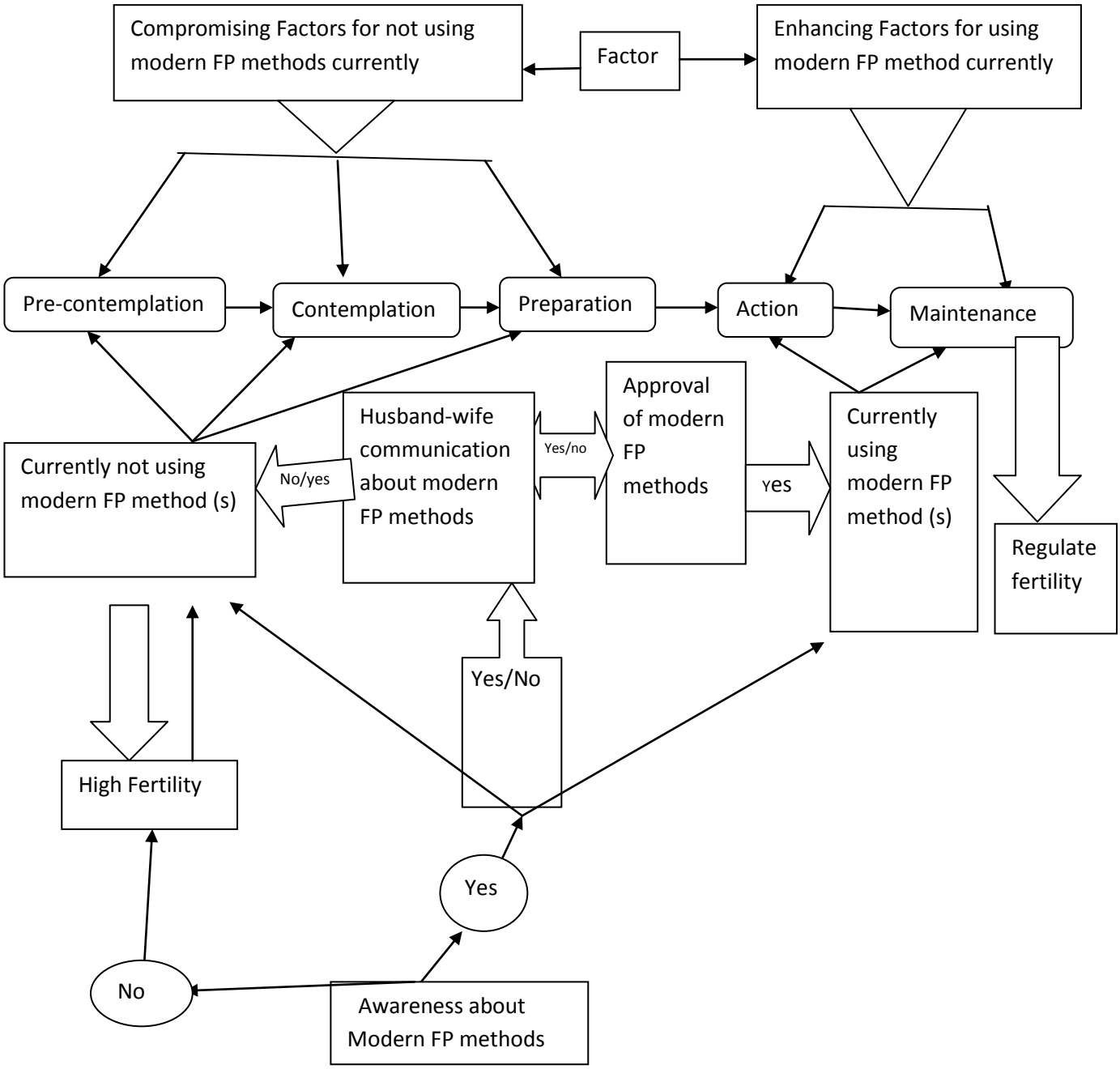

Figure 5: Conceptual framework: Adopted from Trans-Theoretical Model stages behavior change constructs (table 1) (31)

Annex 2: Questionnaire (English / Amharic version)

A. English Questionnaire

I**nstitute of Public Health, University of Gondar**:-

A study questionnaire on the status of men in family planning among currently married men in Dangila town administration, Amhara National Regional state.

Client interview (please give greeting first for the interviewee)

My name is _____. I am a data collector in a research team (project), which is conducted by the University of Gondar, college of medicine and health science, institute of public health. We were interviewing currently married men to know their role in contraceptive method use and the reasons that influence contraceptive method use. I am going to ask you some questions that are not difficult to answer. Your name will not be written in this form and will never be used in connection with any of the information you tell me. You don't have to answer any question that doesn't want to answer and you may end this interview at any time you want to. However, your honest answer to these questions will help us in identifying the role of currently married men in fertility preference and contraceptive use and will enable us to design appropriate interventions or strategies for you, your family, your kebele and the community at large. We would appreciate your collaboration in responding to our questions. The interview will take about **30-40 minutes**.

Consent obtained

1. Yes (if yes say thanks & continue with him) 2. No (if no say thanks, and skip him)

Name and Signature of the data collector who sought the consent_____

Code of interviewee_____ Date of interview _____

Name and signature of the Data collector _____ Date _____

Name and signature of the supervisor: _____ Date _____

Researcher's comment: _____

Part I: - Demographic and socioeconomic characteristics			
No	**Questions for the respondent**	**Responses of the respondent**	**If no Skip to …**
101	Kebele	1. Urban 2. Rural	
102	Age	_____ (in Years or months)	
103	Ethnicity	1. Agew Awi 2. Amhara 3. Other (specify) _____	
104	Religion	1. Orthodox 2. Muslim 3. Protestant 4. Other (specify)_____	
105	Your educational status	1. Illiterate (can't read & write) 2. Can read and write (no formal grade) 3. Elementary school (1-6) 4. Junior high school (7-10) 5. TVETI/Preparatory school (11-12) 6. Higher education (Diploma and above)	
106	Your occupation	1. Government employee 2. Farmer 3. Merchant 4 Daily laborer 5. other (specify) _____	
107	How long has been since you got married with your current wife?	_____ (in Years or months)	
108	What is your Wife's Age?	_____ (in Years)	
109	What is your wife's educational status?	1. Illiterate (can't read & write) 2. Can read and write (no formal grade) 3. Elementary school (1-6) 4. Junior high school (7-10) 5. TVETI/Preparatory school (11-12) 6. Higher education (Diploma and above)	
110	What is your monthly income Birr?	_____ (estimate in Birr)	
111	Who makes decision on the family wealth and asset in your marital life?	1. My self 2. My wife 3. Me and my wife 4. Other (specify) _____	
112	Do you have radio and/or TV in your house?	1. Radio only 2. TV only 3. Both radio & TV 4. None	

PART II Reproductive History of Respondent			
No	**Questions for the respondent**	**Responses of the respondent**	**If no Skip to**
201	At what age did you get married?	_____ years	
202	Do you have child (ren)?	1. No 2. Yes	206
203	If yes to Q 202, at what age did you have your first child?	_____ years	
204	If yes to Q 202, How many children ever born to you?	Total:_____, M_____, F_____	
205	How many of them are alive?	total:_____, M_____, F_____	
206	How many children do you want to have?	Total:____, M____, F_____ I don't know	
207	How many children do you think is good to have?	Total:____, M____, F_____ I don't know	
208	Who is the main decision maker on the number of children you would have?	1. myself 2. my Wife 3. me and my wife 4. my parents 5. my wife's parents 6. Others (Specify)_____	
209	If you preferred to have another child how long would you take to wait before the birth of another child	Below two years 2-3 Years 4-5 years Above five years I don't know other (specify)_____	

Part III Awareness about modern family planning methods of respondents			
No	**Questions for the respondent**	**Responses of the respondent**	**If no Skip to…**
301	Have you ever heard information about modern family planning methods?	1 No 2. Yes	
302	If yes, from where do you get information about modern family planning? (more than one response is possible)	1. Radio 2. health extension workers 3. Other Health professionals 4. wife partners 5. Other (specify)_____	
303	What modern family planning method do you know? (more than one response is possible)	Pills Injectables IUD Norplant	

Part III Awareness about modern family planning methods of respondents			
No	**Questions for the respondent**	**Responses of the respondent**	**If no Skip to…**
		Condom Female sterilization Male Sterilization (vasectomy) Other (specify) _____	
304	What modern male family planning method do you know? (more than one response is possible)	1.Condom 2. vasectomy 3. I don't know 4. other (specify)_____	

PART IV Husband-wife Communication about modern contraceptive use			
No	**Questions for the respondent**	**Responses of the respondent**	**If no Skip to---**
401	Have you discussed about the issue of family planning with your wife within one year prior the data collection?	No Yes	
402	Have you discussed about the issue of family planning with your wife within one month prior the data collection?	1. No 2. Yes	
403	If yes, how many times you discussed with her in the past month?	Once Twice Three times More than three times (specify)_____	
404	What was the topic having you discussed with her? (more than one response is possible)	About number of children you would have Child Spacing Child Limiting Contraceptive methods Other (specify)_____	
405	Who decide mainly on the modern method of Family planning to be used in your marital life when you or your wife needs to use?	1.My self 2.My wife 3.Me and my wife 4. My parents 5. my wife's parents 6. other (specify)_____	
406	Did your wife ever requested for approval of using male modern FP method?	No Yes	

PART IV Husband-wife Communication about modern contraceptive use			
No	**Questions for the respondent**	**Responses of the respondent**	**If no Skip to---**
407	If yes, did you approve her request?	no Yes	
408	If you disapproved, what was your reason?	Respondent refusal Religious prohibition Culture does not allowed Fear of side effect Other (specify)_____	
409	If your wife requests you to use male modern family planning method now, do you approve?	no yes	
410	If you approve, which one do you prefer? (more than one response is possible)	Condom Men sterilization (Vasectomy) Other (specify)_____	
411	If you disapprove, what is your reason?	Respondent refusal Religion prohibition Culture does not allowed Fear of side effect Other (specify)_____	
412	Did your wife ever requested for approval of using modern FP method (for her)?	No Yes	
413	What was your response for the request?	1. Approve 2. Disapprove 3. Other (Specify)_____	
414	If you disapproved, what was your reason?	Respondent refusal Religion prohibition Culture does not allowed Fear of side effect Other (specify)_____	
415	What do you decide, if your wife asks you to use modern family planning for her now?	1. Approved 2. Disapproved 3. Other (Specify)_____	
416	If you disapprove, what is your reason?	1. Respondent refusal 2. Family Disapproved 3.Religion prohibition 4.Culture does not allowed 5.Fear of side effect 6.Desire to have more children 7.Other (specify)_____	

Part V: The Respondent (his wife) Practice of modern contraceptive and stage of change for modern contraceptive use.			
No	**Questions for the respondent**	**Responses of the respondent**	**If no Skip to…**
501	Have you ever used modern FP method?	1. No 2. Yes	
502	If Yes, which type of male modern FP methods you ever used?	1. Condom 2. Vasectomy 3. Other (specify)_____	
503	Are you currently using any modern method of contraceptive?	1. No 2. Yes	506, 507
504	If yes, which type of modern FP methods are you using?	1. Condom 2. Vasectomy (male sterilization) 3. Other (specify)_____	
505	If yes for question 503, how long have you been using the modern FP method?	Less than six months Six months and above	
506	What was your reason for not currently using male modern FP methods? (more than one response is possible)	Respondent refusal Religion prohibition Culture does not allowed Fear of side effect Other (specify)_____	
507	When do you intend/plan to use modern FP method?	Within the next 30 days Within next six months No intension to use within the next six months I don't know when I will start I know nothing Other (specify)_____	
508	Has your wife ever used modern FP method?	1. No 2. Yes 3. I don't know	
509	If yes, which type of modern FP method she ever used? (more than one response is possible)	Pills Injectables Norplant IUD Female sterilization Other (specify)_____	
510	Is your wife currently using any modern method of contraceptive?	No Yes I don't know	514
511	If yes, do you agree/ approve/ for her to use?	1. No 2. Yes	
512	If yes, which type of modern FP methods she is using?	Pills Injectables Norplant IUD	

Part V: The Respondent (his wife) Practice of modern contraceptive and stage of change for modern contraceptive use.			
No	**Questions for the respondent**	**Responses of the respondent**	**If no Skip to…**
		Female sterilization Other (specify)_____	
513	How long has your wife been using the modern FP method?	Less than six months Six months and above	
514	When does she intend/plan to use modern FP method?	Within the next 30 days Within next six months No intension to use within the next six months I don't know when she will start she know nothing Other (specify)____	
515	If you (or your wife) are currently using modern FP methods for, for what purpose are you/your wife using?	1. birth spacing 2. limiting birth 3. other (specify)_____	
516	If you (or your wife) are not using any modern FP method, what is your/her reason? (more than one response is possible)	Respondent refusal Respondent's wives refusal we don't know any modern FP methods we don't knows the source we have health problem we have fear of side effects Religious prohibition cultural problem Fear of infertility . other (specify)_____	

Thank You for your understanding, time and cooperation!!!

B. <u>የአማርኛ መ□□ቅ /Amharic Questionnaire/</u>

በጐንደር ዩኒቨርስቲ፣ የህብረተሰብ ጤና አጠባበቅ ተቋም

በቤተሰብ ክቅ□ □ር□ በትዳር ውስጥ ያሉ ወንዶች ያላቸው ተሳትፎ ላይ ጥናት ለማካሄድ የተዘጋጀ መጠይቅ

ሀ/ <u>መግቢያ</u>

ስሜ ---------- እባላለሁ፡፡ እኔ ከጐንደር ዩኒቨርስቲ ከመጡ የጥናቱ አባላት በመሆን መረ□ አሰባስባለሁ፡፡ የጥናታችን አላማ በትዳር ውስጥ ያሉ ወንዶች በቤተሰብ ዕቅድ ላይ ያላቸው ተሳትፎ በተመለከተ ለማወቅ ነው፡፡

ለ/ የጥናቱ ዋና አላማ

በአሁኑ ወቅት በትዳር ውስጥ ያሉ ወንዶች በቤተሰብ ዕቅድ ላይ ያላቸው ተሳትፎ ለማወቅና ከዚህ ከዘመናዊ የቤተሰብ ዕቅድ መጠቀም ወይም አለመጠቀም ጋር ተያያዥነት ያላቸውን ዋና ዋና ጉዳዮች ለማጥናት ነው፡፡ ይህም ከቤተሰብ ዕቅድ ጋር ትስስር ያላቸው ዘርፈ ብዙ የጤና ችግሮችን በመረዳት የማህበረሰቡ የጤና ኘሮግራም ለማሻሻል □ከሉን አስተዋጽኦ ሊያበረክት እንደሚችል □ታመናል፡፡

እርስ- ለዚህ ጥናት የተመረጡት በእጣ ነው፤ የሚሰጡት መልስ በሚስጢራዊነት ይጠበቃል፡፡ ማለትም በዚህ ጥናት የሚሰበሰበው እርስዎን የሚመለከት መረጃ ከዋናው ተመራማሪ በስተቀር ለማንም አይገለፅም፡፡ በተፈ ማሪም ስምወትን በጥናት ወረቀቱ ላይ መ□ፍ አያስፈልግም፡፡ በከፊል ወይንም ሙሉ በሙሉ በጥናቱ ያለመሳተፍ መብትዎ የተጠበቀ ነው፡፡ ነገር ግን የጥናቱ ውጤት በጥቅል ተተንትኖ ውጤቱ ከታየ በኃላ ለህብረተሰቡ አገልግሎት በሚጠቅም መልኩ ለ□□ሚ እና ሌሎች ለሚመለከታቸው አካላት ይገለፃል፡፡ ስለሆነም ግቡን እንዲመታና ለህብተሰቡ፣ ለእርስወና ለመጭው ትውልድ ጠቀሜታ ስለሚኖረው በጥናቱ እንዲሳተፉ በትህትና እጠይቃለሁ፡፡

ስለዚህ ለቀረቡት ጥያቄዎች መልስ ለመስጠትና ከእኛ ጋር ለተወሰኑ ደቂቃዎች (30 እስከ 40 ደቂቃዎች) አብረን ለመቆየት ፈቃደኛ ነዎት?

1. **አዎ** 2. **አደለሁም**

አዎ ካሉ በሚቀጥለው ገፅ ላሉት ጥያቄዎች መረጃ እንዲሠጡኝ በትህትና እጠይቃለሁ፡፡ አመሰግናለሁ::

- ✓ **ተሳታ□□ በቃለ መ□□ቁ □ቃ□ኛ ከሆነ የቃለ መጠይቁ አቅራቢ ፊርማ _____**
- ✓ **□ተ□□ቂ□ ኮ□: _____**
- ✓ **ቃለ መጠይቁ የተደረገበት ቀን _____/ 2004 □ም**
- ✓ **□□□ቂ□ ሥም/ኮ□/_____ □ርማ_____ ቀን _____/ 2004 □ም**
- ✓ **□ተቆ□□ሪ□ ስም/ኮ□/_____ □ርማ_____ የተረጋገጠበት ቀን _____/ 2004 □ም**
- ✓ **የተማራማሪው አስተያየት:_____**

	ክፍል 1፡- □ስነ-ህዝብና ማህበራዊ ጉዳዮች በተመለከተ የተዘጋጁ ጥያዎች		
ተ.ቁ	የቀረቡ ዓ□ቄ- ች	አማራጭ መልሶች	የለም ከሆነ □□ ተ.ቁ... □ለ□
101	ቀበሌ	ከተማ □□ር	
102	እ□ሜ	_____ ዓመት	
103	ብሄር	አገው አዊ አማራ 3. ሌላ (□□ቀስ) _____	
104	ሀይማኖት	ኦርቶዶክስ 2. ፕሮቴስታንት 3. ሙስሊም ሌላ (□□ቀስ)_____	
105	የትምህርት ደረጃ	ያልተማረ (ማንበብና መፃፍ የማይችል) ማንበብና መፃፍ የሚችል (መደበኛ ት/ት □ልተማረ) አንደኛ □ረ□ (1-6) መለስተኛ ሁለተኛ □ረ□ (7-10) መሰናዶ (11-12) / ቴክኒክ እና ሙያ 6. ከፍተኛ ትምህርት (ዲፕሎማና ከዚያ በላ□)	
106	ስራ	የመንግስት ሠራተኛ አርሶ አደር 3. ነጋዴ 4. የቀን ሠራተኛ ሌላ (□□ቀስ) _____	
107	ባለቤትዎ ጋር ትዳር ከመሰረቱ ስንት ጊዜ ሆነወት?	_____ ዓመት	
108	የባለቤትዎ ዕድሜ ስንት ነው?	_____ ዓመት	
109	□ባለቤትዎ የትምህርት □ረ□?	ያልተማረች (ማንበብና መፃፍ የማትችል) ማንበብና መፃፍ የምትችል (መደበኛ ት/ት ያለተማረች) አንደኛ □ረ□ (1-6) መለስተኛ ሁለተኛ □ረ□ (7-10) መሰናዶ (11-12) / ቴክኒክ እና ሙያ ከፍተኛ ትምህርት (ዲፕሎማና ከዚያ በላይ)	
110	የባለቤትዎ ስራ	የቤት እመቤት የመንግስት ሠራተኛ 3. ነጋዴ	

	ክፍል 1፡- □ስነ-ህዝብና ማህበራዊ ጉዳዮች በተመለከተ የተዘጋጁ ጥያዎች		
ተ.ቁ	የቀረቡ ዓ□ቄ- ች	አማራጭ መልሶች	የለም ከሆነ □□ ተ.ቁ... □ለ□
		4. የቀን ሠራተኛ 5. ሌላ (□□ቀስ) _____	
111	□ርሃዊ □ኪ- በብር	_____ ብር	
112	ባፈራችሁት ንብረትና ገንዘብ በዋናነት የሚወስነው ማን ነው?	እኔ ባለቤቴ እኔና ባለቤቴ በጋራ የኔ ወላጆች የባለቤቴ ወላጆች ሌላ (□□ለ□) _____	
113	በቤታችሁ ውስጥ ሪ□□ ወይም ቴለቪዥን አላችሁ?	ሪዲዮ ብቻ ቴሌቪዥን ብቻ ሁለቱም አለን ምንም የለም_____	

□□ል 2፡ የስነ-ተ□ል□ □ና ታሪክ የሚመለከቱ ጥያቄዎች			
ተ.ቁ	የሚጠየቁ ጥያቄዎች	አማራጭ መልሶች	የለም ከሆነ □□ ተ.ቁ ... □ለ□
201	ለመ□መሪ□ □□ ሲ□□ኩ ዕድሜዎ ስንት ነበር?	_____ ዓመት	
202	ልጆች አለዎት?	አዎ □ለም	206
203	የመጀመሪያ ልጅዎን ሲወልዱ ዕድሜዎ ስንት ነበር?	_____ ዓመት	
204	እስከአሁን ድረስ ስንት ልጆችን ወልደዋል?	ወንዶች፡ ___ ፣ ሴቶች፡ ___	
205	አሁን በህይወት ያሉ ልጆች ስንት ናቸው?	ወንዶች፡ ___ ፣ ሴቶች፡ ___	
206	ስንት ልጆች እንዲኖርዎት □□ልፉ?	ወንዶች፡ ___ ፣ ሴቶች፡ ___	
207	ወላጆች ስንት ልጆች ቢኖራቸው ዓ ሩ ነው ይላሉ?	ወንዶች፡ ___ ፣ ሴቶች፡ ___	
208	ስንት ልጆች መውለድ እንዳለባችሁ ማን ነው የሚወስነው?	1) እኔ 2) ባለቤቴ 3) እኔና ባለቤቴ በጋራ 4) የኔ ወላጆች 5) የባለቤቴ ወላጆች 6) ሌላ (□□ለ□) _____	
209	ተጨማሪ ልጅ ከፈለጉ ከስንት □□ በኃላ አራርቀው መ□ለ□ □□ልፉ?	1) ከ2 ዓመት በፊት 2) ከ2-3 ዓመት	

☐☐ል 2፡ የስነ-ተ☐ል☐ ☐ና ታሪክ የሚመለከቱ ጥያቄዎች			
ተ.ቁ	የሚጠየቁ ጥያቄዎች	አማራጭ መልሶች	የለም ከሆነ ☐☐ ተ.ቁ ... ☐ለ☐
		3) ከ4- 5 ዓመት 4) ከ 5 ዓመት በላይ 5) አላውቅም ሌላ (☐☐ቀስ) _____	

☐☐ል 3፡- ስለ ዘመናዊ ቤተሰብ ዕቅድ ዘዴ የእውቀት መለኪያ የሚመለከቱ ጥያቄዎች			
ተ.ቁ	☐ሚ☐የቁ ጥያቄዎች	አማራጭ መልሶች	የለም ከሆነ ☐☐ ተመለከተው ተ.ቁ ይለፉ
301	ስለ ዘመናዊ የቤተሰብ ዕቅደ ☐እ ሰምተ☐ ☐☐ቃሉ?	አዎ ☐ለም	
302	መልስዎ አዎ ከሆነ መረጃው ከየት ነው የሰሙት (ከአንድ በላይ መልስ መስጠት ይቻላል)	1) ከሪ☐☐ 2) ኩቴሌቭዥ☐ን 3) ከጤና ኤክስቴንሽን ሠራተኞች 4) ከሌሎች ጤና ባለሙያዎች ከበጎ ፈቃድ ጤና መልእክተኞች ከሌላ (ይጠቀስ) _____	
303	የትኛውን ዘመናዊ የቤተሰብ ዕቅድ ዘዴ ያውቃሉ? (ከአንድ በላይ መልስ መስጠት ይቻላል)	የወሊድ መከላከያ ክኒን /እንክብል/ በመር☐ ☐ሚሰጓ በማህፀን ውስጥ የሚቀመጥ ሉ☐ (IUD) በክንድ ቆዳ ስር የሚቀመጥ /☐ሚቀበር/ ኮንዶም የሴቷ ማህፀን መቋጠር የወንዱን የዘር ፍሬ መለየት /መቋ☐ር/ ሌላ (☐☐ቀስ) _____	
304	የትኛውን ዘመናዊ የወንድ ☐ቤተሰብ ክቅ☐ ☐እ ☐☐ቃሉ?	1) ኮንዶም 2) ቋሚ የወንዶች የዘር ፍሬ መለየት (መቋ☐ር) 3) አላውቅም 4) ሌላ (☐ዓ ቀሱ) _____	

ክፍል 4፡ በቤተሰብ ዕቅድና በዘመናዊ የቤተሰብ ዕቅድ ዘዴ አጠቃቀም ዙርያ በባልና በሚስት የሚደረግ ውይይት የተመለከቱ ጥያቄዎች

ተ.ቁ	የሚጠየቁ ጥያቄዎች	አማራጭ መልሶች	የለም ከሆነ □□ ተመለከተው ተ.ቁ □ለ□
401	ባለፈው ዓመት በቤተሰብ ዕቅድ ዙርያ ከባለቤትሞ ጋር ተ□□□ታችኋል?	አሞ □ለም	
402	ባለ□□· □ር በቤተሰብ ክቅ□ □ር□ ከባለቤትሞ ጋር ተ□□□ታችኋል?	አሞ □ለም	405
403	መልስሞ አሞ ከሆነ፤ ስንት ጊዜ ተ□□ይታችኋል? (402)	አንድ ጊዜ ሁለት ጊዜ ሶስት □□ ከሶስት □□ በላይ (□□ቀስ) ----------	
404	ስለምን ነበር የተወያያችሁት? (402) (ከአንድ በላይ መልስ መስጠት ይቻላል)	ስንት ልጆች ሊኖረን ይገባል በሚል ርክሰ □□□ ስለ አራርቆ መውለድ መወሰን (ተጨማሪ ልጅ መውለድ ይብቃን) ስለ □ቤተሰብ ክቅ□ □ጸ ሌላ (□□ቀስ)_____	
405	እርስሞ ወይንም ባለቤትሞ ዘመናዊ □ቤተሰብ □ክቅ□ □ጸ መ□ቀም ስትፈልጉ ማን ነው በዋናነት የሚወስነው?	እኔ ባለቤቴ እኔና ባለቤቴ በጋራ 4. የኔ ወላጆች 5. የባለቤቴ ወላጆች ሌላ (□□ለ□) ----------	
406	ባለቤትሞ የወንድ የቤተሰብ ዕቅድ □ጸ እንዲጠቀሙ ጠይቃዎት ታውቃለች ?	አሞ የለም	409
407	መልስሞ አሞ ከሆነ ለመጠቀም ተስማሙ?	አሞ □ለም	408

ክፍል 4፡ በቤተሰብ ዕቅድና በዘመናዊ የቤተሰብ ዕቅድ ዘዴ አጠቃቀም ዙርያ በባልና በሚስት የሚደረግ ውይይት የተመለከቱ ጥያቄዎች			
ተ.ቁ	የሚጠየቁ ጥያቄዎች	አማራጭ መልሶች	የለም ከሆነ □□ ተመለከተው ተ.ቁ □ለ□
408	ያለተስማሙበት ምክንያትዎ ምን ነበር (407)? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. ስለማል□ልፅ 2. ሀይማኖቱ ስለማይፈቅድ 3. ባህላችን ስለማይፈቅድ 4. የጎንዮሽ ጉዳት ስለምፈራ 5. ሌላ (□□ቀስ)	
409	ባሁኑ ወቅት ባለቤትዎ የወንድ ዘመናዊ የቤተሰብ ዕቅድ እንዲ□ቀሙ ብትጠይቀዎት ይስማማሉ?	አዎ □ለም	411
410	ከተስማሙ፣የትኛውን ይመርጣሉ (409)? (ከአንድ በላይ መልስ መስጠት ይቻላል)	ኮንዶም የወንድ የዘር ፍሬ መቋጠር (መለየት) ሌላ (□□ቀስ)----------	
411	የማይሰማሙበት ምክንያትዎ ምን ድን ነው (409)? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. ስለማል□ልፅ 2. ሀይማኖቱ ስለማይፈቅድ 3. ባህላችን ስለማይፈቅድ 4. የጎንዮሽ ጉዳት ስለምፈራ 5. ሌላ (□□ቀስ).....	
412	ባለቤትዎ ዘመናዊ የቤሰብ ዕቅድ ዘዴ መ□ቀም □ልፉ □እርስ- □ቃ□ □□ቃ ታውቃለች?	1. አዎ 2. □ለም	414
413	አዎ ከሆነ፤ መልስዎ ምን ነበር?	እንድትጠቀም ፈቀዱኩላት እንድትጠቀም አልፈቀድኩላትም አላስታ□ስም	
414	ካልፈቀዱ ምክንያትዎ ምን ነበር (413)?	1. ስልማል□ልፅ 2. ሀይማኖታችን ስለሚከለክል 3. ባህላችን ስለሚከለክል	

ክፍል 4፡ በቤተሰብ ዕቅድና በዘመናዊ የቤተሰብ ዕቅድ ዘዴ አጠቃቀም ዙርያ በባልና በሚስት የሚደረግ ውይይት የተመለከቱ ጥያቄዎች			
ተ.ቁ	የሚጠየቁ ጥያቄዎች	አማራጭ መልሶች	የለም ከሆነ □□ ተመለከተው ተ.ቁ □ለ□
		4. የጎንዮሽ ጉዳት/ ችግር ስለሚያስከትል 5. ሌላ (□□ል□)_____	
415	በአሁን ወቅት ባለቤትም የቤሰብ ዕቅድ ዘዴ ልትጠቀም ፈልጋ ብትጠይቅም ምን ይላሉ?	□□ቅ□ላ□ሎህ አለፈቅድላትም	
416	ካልፈቀዱ ምክንያትም ምን ነው?	1. ስልማል□ልፅ 2. ሀይማኖታችን ስለሚከለክል 3. ባህላችን ስለሚከለክል 4. የጎንዮሽ ጉዳት/ ችግር ስለሚያስከትል 5. ሌላ (□□ል□)_____	

ክፍል 5፡ ስለ ዘመናዊ የቤተሰብ ዕቅድ ዘዴ አጠቃቀም እና በቤተሰብ ምጣኔ ላይ የባህሪ ለውጥ ደረጃ የመለኩ ጥያቄዎች			
ተ.ቁ	የሚጠየቁ ጥያቄዎች	አማራጭ መልሶች	□ለም ከሆነ □□ ተ.ቁ ... □ለ□
501	እርስዎ የወንድ ዘመናዊ የቤተሰብ ክቅ□ □ጸ ተ□ቅመ□ም □□ቃሉ?	አዎ □ለም	503
502	መልሰዎ አዎ ከሆነ (501) የትኛውን □ጸ ተ□ቅመ□ም □□ቃሉ?	ኮንዶም የወንድ የዘር ፍሬ መለየት/መቋጠር ሌላ (□□ቀስ)_____	
503	በአሁኑ ወቅት እርስዎ የወንድ ዘመናዊ የቤተሰብ ዕቅድ ዘዴ እየተጠቀሙ ነው?	አዎ □ለም	506
504	መልሰዎ አዎ ከሆነ(503) የትኛውን □ጸ □□ቀማሉ?	ኮንዶም የወንድ የዘር ፍሬ መለየት/መቋጠር ሌላ (□□ቀስ)_____	
505	መጠቀም ከጀመሩ ስንት ጊዜ ሆነወት	ስድስት ወር አልሞላኝም ስድስት ወር እና ከዚያ በላይ ሆኖኛል	

ክፍል 5፡ ስለ ዘመናዊ የቤተሰብ ዕቅድ ዘዴ አጠቃቀም እና በቤተሰብ ምጣኔ ላይ የባህሪ ለውጥ ደረጃ የመለኩ ጥያቄዎች			
ተ.ቁ	የሚጠየቁ ጥያቄዎች	አማራጭ መልሶች	□ለም ከሆነ □□ ተ.ቁ ... □ለ□
506	በአሁኑ ወቅት የወንድ ዘመናዊ □ቤተሰብ ክቅ□ □ጸ □ማ□□ቀሙ ለምንድን ነው?	1. ስለማል□ልፅ 2. ሀይማኖቴ ስለማ□□ቅ□ 3. ባህላችን ስለማይፈቅድ 4. የጎንዮሽ ጉዳት ስለምፈራ 5. ሌላ (□□ቀስ).....	
507	ተጠቃሚ ካልሆኑ፡ መቸ ለመጠቀም አስበዋል/አቅደዋል?	እስከ አንድ ወር ጊዜ ውስጥ ለመጠቀም አስቤአለሁ እስከ ስድስት ወር ጊዜ ውስጥ ለመጠቀም አስቤአለሁ እስከ ስድስት ወር ጊዜ ውስጥ ለመ□ቀም ኣላሰብኩም/አላቀድኩም/ ምንም የምያውቀው ነገር የለኝም ሌላ (□□ቀስ)----------	
508	ባለቤተ- □ቤተሰብ ክቅ□ □ጸ ተ□ቅማ ታ□ቃለች?	አም ጭራሽ ተጠቅማ አታ□ቅም አላውቅም	
509	ተ□ቅማ □ምታውቅ ከሆነ የትኛ ውን ዘመናዊ የቤተሰብ ዕቅድ ዘዴ ተጠቀመች?(ከአንድ በላይ መልስ መስጠት ይቻላል)	የወሊድ መከላከያ ክኒን /እንክብል/ በመር□ □ሚሰዓ በማህፀን ውስጥ የሚቀመጥ ሉፕ (IUD) በክንድ ቆዳ ስር የሚቀመጥ /□ሚቀበር/ የሴቷ ማህፀን መቋጠር ሌላ (□□ቀስ) _____	
510	ባለቤተም ዘመናዊ የቤተሰብ ዕቅድ □ጸ እየተጠቀመች ነው?	አም □ለም 3. አላውቅም	514
511	መለስም አም ከሆነ፣ መጠቀሚ እርስ- ተስማሚተ□በታል /□ቅ□□ል?	አም አልተስማማሁም/አልፈቀድኩም ሌላ (□□ቀስ)_____	
512	እየተጠቀመች ከሆነ የትኛውን ዘመናዊ የቤተሰብ ዕቅድ ዘዴ ትጠቀማለች?	የወሊድ መከላከያ ክኒን /እንክብል/ በመር□ □ሚሰዓ በማህፀን ውስጥ የሚቀመጥ ሉፕ (IUD) በክንድ ቆዳ ስር የሚቀመጥ /□ሚቀበር/ የሴቷ ማህፀን መቋጠር ሌላ (□□ቀስ) _____	

ክፍል 5፡ ስለ ዘመናዊ የቤተሰብ ዕቅድ ዘዴ አጠቃቀም እና በቤተሰብ ምጣኔ ላይ የባህሪ ለውጥ ደረጃ የመለኩ ጥያቄዎች			
ተ.ቁ	የሚጠየቁ ጥያቄዎች	አማራጭ መልሶች	□ለም ከሆነ □□ ተ.ቁ ... □ለ□
513	ባለቤትሥ ዘመናዊ የቤተሰብ ዕቅድ ዘዴ መጠቀም ከጀመረች ስንት ጊዜ ሁኗታል?	6 ወር አልሞላትም 6 □ር እና ከዚያ በላይ ሆኗታል አላውቅም	
514	እየተጠቀመች ካልሆነ መቸ መጠቀም ትጀምራለች?	በሚቀጥለው አንድ ወር ጊዜ ውስጥ መጠቀም ትጀምራለች በሚወጥለው ስድስት ወር ጊዜ ውስጥ መጠቀም ትጀምራለች በሚወጥለው ስድስት ወር ጊዜ ውስጥ መጠቀም አትጀምርም ምንም የምታውቀው ነገር የለላትም አላውቅም ሌላ (□□ቀስ)_____	
515	እርሰሥ ወይም ባለቤትሥ አሁን ዘመናዊ የቤተሰብ ዕቅድ ዘዴ እየተጠቀሙ ከሆነ፤ ለምን ዓላማ ነው የምትጠቀሙት?	አራርቆ ለመውለድ ከአሁን በኋላ መውለድ ስለማንፈልግ ሌላ(□□ቀስ)	
516	እርሰሥ ወይም ባለቤትሥ አሁን ዘመናዊ የቤተሰብ ዕቅድ ዘዴ □ተጠቃሚ ናለሆናችሁ ምክንያታችሁ ምንድነው?	እኔ መጠቀም ስለማልፈልግ ባለቤቴ መጠቀም ስለማትፈልግ ዘመናዊ የወሊድ መከላከያ መኖሩን ስለማናውቅ የት መጠቀም እንደሚቻል ስለማናውቅ የጤና ችግር ስላለብን የጎንዮሽ ጉዳት ስለምንፈራ ሃማኖታችን ስለማይፈቅድ ባህላችን ስለማይፈቅድ መሃን ሊያደረግ ይችላል ብለን ስለምንፈራ ሌላ(□□ቀስ)	
517	ያገቡ ወንዶች ተጨማሪ ልጅ መውለድ ካልፈለጉ ቋሚ የወንዶች □□ር □ራ ማስቋጠር ይችላሉ፡፡	እ□ፅ□ሎህ አልደግፍም በዚህ ጉዳይ ላይ ምንም ማለት አልፈልግም	

ጊዜሥ ሰውተው ላደረጉልኝ ትብብር እጅግ በጣም አመሰግናሎህ!!!

Annex 3: Information Sheet and Consent Forms (English / Amharic Version)

A. English Information sheet and Consent form

Title of the Research Project

Men involvement in family planning by using Trans-Theoretical Model among married men in Dangila town administration, Ethiopia

Name of Principal Investigator: Mulat Nigus Alemu (BSc)

Name of the Organization: Institute of Public Health, Gondar College of Medicine and Health Sciences, University of Gondar.

Name of the Sponsor: University of Gondar

Introduction

This information sheet and consent form is prepared with the aim of explaining the research project that you are asked to join by the group of research investigators. The aim of the research project is to assess status of men involvement in family planning among married men in order to regulate fertility in marital sphere of life that contributes to better quality of life in the study area. The research group includes trained diploma nurses, tone supervisor from the town health office, principal investigator, and two advisors from University of Gondar.

Purpose of the Research Project

The aim of the research project is to assess men involvement in family planning among married men in order to regulate fertility in marital sphere of life that contributes to better quality of life in the study area. The results of this study will be used as a basis, especially in the study area, to design appropriate intervention programs to address the problem.

Procedure: To assess status of men involvement in family planning among married men in order to regulate fertility in marital sphere of life that contributes to better quality of life in the study area, I invite you to take part in my project. If you are willing to participate in this project, you need to understand and sign the agreement form. Then you will be asked to give your responses by the data collectors. For participants who are not capable of giving responses to the questions either their illness or their being unwilling to participate, they will be exempted.

For this questionnaire based study, participants are all those married men who fulfill the inclusion criteria. All the responses given by the participants and results obtained will be kept confidential using coding system whereby no one will have access to your responses.

Risk and discomfort

By participating in this research project, you may fill that it has some discomfort especially on wasting your time(about 30-45 minutes) but this will not be too much as compared with its benefit it contributes to regulate fertility in the future for better quality of life. No risk in participating in this study project.

Benefits:

If you participate in this research, you may not get direct benefit but your participation is likely to help us in identifying the men awareness, involvement, stage of behavior change and factors that influence men involvement in contraceptive use that will have a benefit of choosing appropriate and cost effective family planning strategies to regulate fertility.

Incentives:

You will not be provided any incentive to take part in this research.

Confidentiality:

The information that we collect from this research project will be kept confidential. Information about you that will be collected from the study will be stored in a file, which will not have your name on it, but a code number will be assigned to it. Which number belongs which name will be kept under lock and key, and it will not be revealed to anyone except the principal investigator.

Right to refuse:

You have full right to refuse from participating this research (you can choose not to respond some or all questions) if you do not wish to participate; and this will not affect your education.

Whom to contact:

This research project will be received and approved by Ethical Committee and institute of Public Health of University of Gondar.

If you have any question, contact any of the following individuals and you may ask at any time you want:

1. **Mulat Nigus Alemu**: Principal investigator

   Institute of Public Health, University of Gondar

   Tel: 0911988892

2. **Mr Abebaw Gebeyehu**: Advisor

   Institute of Public Health, University of Gondar

   Tel: 0920314519

3. **Mr. Getahun Kebede**: Advisor

   Institute of Public Health, University of Gondar

   Tel: 0913379518

B. <u>የመረጃና የስምምነት ቅጽ (Information sheet and consent)</u>

የትናቱ ርዕስ

በአማራ ብሔራዊ ክልለላዊ መንግስት በዳንግላ ከተማ አስተዳደር በትዳር ውስጥ የሚገኙ ወንዶች በቤተሰብ ዕቅድ ዙርያ ያላቸው ተሳትፎ እና ተያያዥነት ባላቸው ጉዳዮች የሚካሄድ ጥናት፡፡

የዋና ተማራማሪ ሥም፡ **ሙላት ንጉስ አለሙ**

□□ር□ቱ ሥም፡ **በጎንደር ዩኒቨርሲቲ የህብረተሰብ ጤና አጠባበቅ ተቋም**

የስፖንሰር ድርጅት ሥም፡ _____

መፅቢ□

ይህ የመረጃና የስምምነት ውል የተዘጋጀው እርስ- ተሳታ□ እንዲሆኑ ስለተጋበዙበት በምርምር ቡድኑ የሚካሄ□□ ጥናት በተመለከተ መግለጫ ለመስጠት ነው፡፡ የምርምር ፕሮጀክቱ ዋና ዓላማ የዳንግላ ከተማ አስተዳደር በትዳር ውስጥ የሚገኙ ወንዶች በቤተሰብ ዕቅድ ዙርያ ያላቸው ተሳትፎና ተያያዥነት ባላቸው ጉዳዮች ማጥናት ነው፡፡ የምርምር ቡድኑ ለዚህ ጥናት የሰለጠኑ እና በነርስንግ ሙ□ □□ሎማ □ኛ ዓመት ተማሪዎች፣ ሱፐርቫይሮች፣ ዋና ተመራማሪ እና ከጎንደር ዩኒቨርሲቲ አማካሪዎችን ያካተተ ነው፡፡

የጥናቱ ዓላማ

የዚህ ጥናት ዓላማ በዳንግላ ከተማ አስተዳደር በትዳር ውስጥ የሚገኙ ወንዶች በቤተሰብ ዕቅድ ዙርያ ጥናት ማካሄድ ነው፡፡ ብሎም ጥናቱ በትዳር ውስጥ ያሉ ወንዶች በቤተሰብ ዕቅድ ዙርያ ያላቸው ተሳትፎ ያሉበት የባህሪ ደረጃ በማጥናት ለፈፃሚ አካላት እና ሌሎች የሚመለከታቸውን አካላት አስፈላጊውን መረጃ ይሰጣል ተብሎ ይጠበቃል፡፡

□ተሳትፎ ሁኔታ (ሂደት)፡ በትዳር ውስጥ ያሉ ወንዶች በቤተሰብ ዕቅድ ያላቸው ተሳትፎ እና ከዚህ ፉር በተ□□ዘ ያላቸውን ችግር ለማወቅ ይረዳ ዘንድ በዚህ ጥናት እንዲሳተፉ ጋብዘነወታል፡፡ በ□ህ ጥናት ውስጥ ለመሳተፍ ከተስማሙ ስምምነቱን መረዳትና እንዲሁም በቃልዎ ማረጋገጥ □□ብ- ታል፡፡ በዚህ ጥናት ሲሳተፉ መረጃ ሰብሳቢው የሚጠይቅዎትን ጥያቄ እንዲመልሱልኝ □ቃ□ኛነትዎን እ□□ቃለሁ፡፡ በህመም ወይም በሌላ ችግር ምክንያት መሳተፍ ካልቻሉ አይገደዱም፡፡ በዚህ ጥናት የሚሳተፉ በዳንግላ ከተማ ያሉ ባለትዳር ወንዶች ሲሆኑ የሚሰጡት መልስም በሚስጥ ር □ጠበቃል፡፡

1. **በጥናቱ ሊከሰቱ የሚችሉ ስጋቶችና የምቾት መጓደሎች፡**

በ□ህ ጥናት መሳተፍዎ ምናልባት ጊዜዎን ሊሻማብዎ ይችል ይሆናል፡፡ ነገር ግን የጥናቱ ውጤት ወደፊት በከተማው/ወረዳው/ና በሀገራችን የብተሰብ ዕቅድ እና ከቤተሰብ ዕቅድ መሻሻል ከሚሰጠው ጥቅም አንጻር ይህን ያህል አ□□ለም፡፡

2. ጥቅሞች

በዚህ ጥናት በመሳተፍዎ የተለየ ጥቅም አያገኙም። ነገር ግን የእርስዎ በጥናቱ ላይ መሳተ□ በትዳር ውስጥ ያሉ ወንዶች በቤተሰብ ዕቅድ ያላቸው ተሳትፎ ለማሳደግ የሚደረገው ጥረት ለማሻሻል ከፍተኛ ሚና ይጫወታል።

3. ማካካሻ

በዚህ ጥናት በመሳተፍዎ ምንም ዓይነት ማካካሻ አይሰጥዎትም። ነገር ግን በጥናቱ በመሳተፍዎ ምስጋናችን ከፍ ያለ ነው።

4. ምስ□ር ስለመ□በቅ

የሚሰጡን መልስ እንዲሁም የጥናቱ ውጤት በሚስጥርነት ይጠበቃል። ለዚህ ጥናት የሚሰበሰበው እርስዎን የሚመለከት መረጃ በማህደር የሚቀመጥ ሲሆን ማህደሩም በእርስዎ ስም ሳይሆን በተለያ ኮድ ሲቀመጥ ከዋናው ተመራማሪ በስተቀር ለማንም አይገለፅም።

5. በጥናቱ ያለመሳተፍ መብት፡

በጥናቱ ላለመሳተፍ ከፈለጉ በዚህ ጥናት ያለመሳተፍ፣ ከአንድ በላይ እንዲሁም ሁሉንም ጥያቄዎች አለመመለስ ይችላሉ። በዚህ ጥናት ባለመሳተፍዎ ወይም በከፊል ሆነ በሙሉ ጥያቄዎችን ባለመመለስ- በት/ቤቱ □ሚያጡት አገልግሎት አይኖርም።

6. መረ□ ስለማፅ ኘት

ይህ ጥናት በጎንደር ዩኒቨርሲቲ የስነ ምግባር ኮሚቴና የህብረተሰብ ጤና አጠባበቅ ትምህርት ተቋም ተከልሶ የሚፀድቅ ይሆናል። ማንኛ□ም ዓ□ቄ ካለዎት ከሚከተሉት ማንኛውም ሰው በሚፈልጉት ጊዜ ማነጋገር ይችላሉ።

ሀ. <u>ሙላት ንጉስ አለሙ</u> ፡- ዋና ተመራማሪ

ስ.ቁ: 0911988892

ለ. <u>አቶ አበባው ገበዮሁ</u>፡- አማካሪ

ስ. ቁ: 0920314519

ሐ. <u>አቶ □ታሁን ከበደ</u>፡- አማካሪ

ስ.ቁ: 0913379518

Annex 4: Thesis submission forms

A. Declaration

I, the undersigned, senior MPH student declare that this thesis is my original work in partial fulfillment of the requirement for the degree of Master of Public Health.

Name of Student: Mulat Nigus Alemu

Signature: _____

Place of submission: Institute of public Health, University of Gondar.

Date of Submission: _____

This thesis work has been submitted for examination with my/ our approval as university advisor(s).

Advisors:

	Name	Signature
1.	Mr. Abebaw Gebeyehu	_____
2.	Mr. Getahun Kebede	_____

B. **ASSURANCE OF INVESTIGATOR**

The undersigned agrees to accept responsibility for the scientific, ethical and technical conduct of the research project and for provision of required progress reports as pre terms and conditions of the research and publications office of the University of Gondar.

Name of the student: Mulat Nigus Alemu

Date: _____ Signature: _____

Approval of the advisor (s)

Advisors

Name	Signature	Date
1. Mr. Abebaw Gebeyehu	_____	_____
2. Mr. Getahun Kebede	_____	_____